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JANUARY 1976

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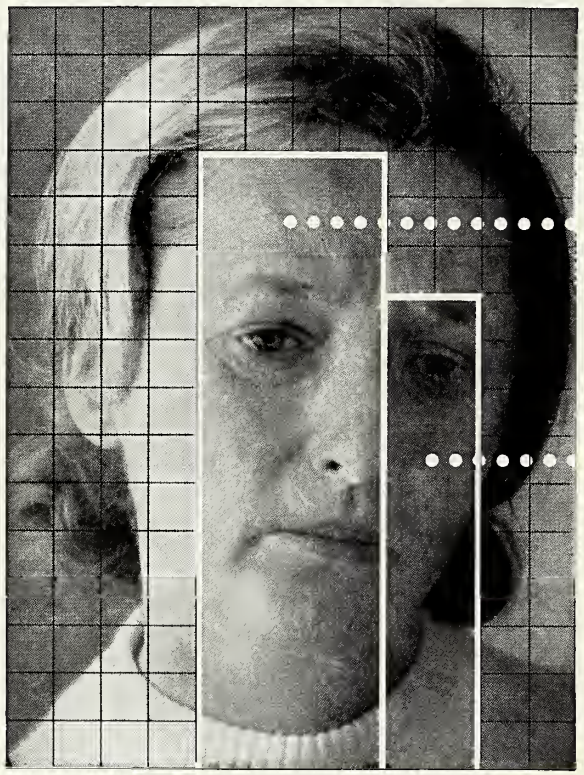

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IOWA Medical Miscellany

CONSUMMATE NEGOTIATIONS . . . In a December 11 negotiating session with HEW, the Iowa Foundation for Medical Care reached agreement on a contract to permit the IFMC to function as the conditional Professional Standards Review Organization (PSRO) for the state. Formal signing of the contract is expected within the near future.

PROFESSIONAL LIABILITY . . . Legislative Interim Study Committee on Medical Liability is meeting January 5 and 6 to finalize its intentions for the 1976 session of the Iowa General Assembly. IMS representatives reviewed the Society's proposals with the Committee on December 10. Eight different IMS items—which could involve legislative action—have been shared, at least in conceptual form, with the lawmakers.

SPORTS MEDICINE . . . Plans for a 1976 Sports Medicine Conference are in process with the day-long event for coaches and physicians scheduled for April in Des Moines. The conference is a joint venture of the IMS and the Iowa High School Athletic Association.

HEALTH PLANNING . . . Selection of representatives to serve on the Iowa Health Systems Agency (HSA) Board of Directors and sub-area advisory councils is now in process. IMS has been active in seeking adequate physician representation on these several bodies. Anticipation is that formal application for official HSA status will be made to HEW in January. See President's Page for further comment.

LEGISLATIVE SEMINAR . . . Upcoming medical legislative issues will be reviewed January 7 at Society Headquarters in an IMS Seminar for Legislative Contact Men.

CONFER WITH U. OF I. . . . The IMS Board of Trustees will meet with representatives of the College of Medicine January 21 to review various matters of mutual interest. Conference is in conjunction with regular monthly meeting of the Board and will be followed on January 22 with the quarterly session of the IMS Executive Council.

IMMUNIZATION . . . Subject of possible legislation to make immunization of children compulsory in Iowa was discussed December 10 at a meeting attended by representatives of the IMS Committee on Maternal and Child Health. Current position of IMS favors broad effort to provide immunization but on a voluntary basis.

REPORTING SYSTEM . . . Toll-free telephone (1-800-362-2736) is now available for physician use in reporting vaccine-preventable diseases to the State Department of Health. Use of the line is encouraged except in the instance where a local health department has its own reporting system.

HMO BEGINS . . . Rural Health Services (RHS), Iowa's first health maintenance organization, has experienced a brisk enrollment in November and December. The program is open to Davis County residents or patients of Davis County physicians. IMS Committee on Alternate Delivery Systems has followed development of the project in line with a House of Delegates' action supporting experimentation of this type.

HOSPITAL STAFF MAILING . . . Two documents dealing with hospital/medical staff relations were mailed in December to chiefs of Iowa hospital medical staffs. The mailing included (1) a summary of a paper entitled "The Medical Staff and the Hospital," prepared by IMS legal counsel, and (2) the AMA booklet, "Physician-Hospital Relations/1974."

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IOWA Medical Miscellany

PROFESSIONAL LIABILITY . . . Legislative Interim Committee on Medical Malpractice concluded its service January 5. Committee's final report to the General Assembly will include recommmendations to (1) give the Board of Medical Examiners added regulatory power to assure quality care, (2) give the court further responsibility in evaluating contingency fees, and (3) to modify the Iowa code to allow for experimentation with arbitration. Also, in its appendix, the committee's report will refer to legislation which (a) provides a $100,000 ceiling on awards for non-economic loss, and (b) allows for periodic payment of an award to the plaintiff in lieu of a lump-sum windfall.

NEXT ACTION . . . Report of the Interim Committee will be referred to full Assembly but principal legislative activity will have to occur in the House and Senate Commerce committees early in the session. IMS legislative representatives will continue to work closely with these committees.

HEALTH PLANNING . . . Interim Board of the Iowa Health Systems Agency decided January 5 to press forward with its program. Application is to be submitted to HEW January 19 for conditional designation and one-year's funding of $1.2 million. Efforts to consummate the 30-member HSA Board of Directors are also moving ahead. Sub-area provider and consumer designees are to meet January 26 to fill the 9 at-large spots on the HSA Board. Detailed report on HSA developments was sent January 7 to county society presidents and secretaries.

BRIEFING . . . When selection of HSA Board and areawide advisory councils is completed, IMS hopes to arrange a special seminar for physician members of these bodies and for other interested Society members.

LCM SEMINAR . . . More than 60 Iowa physicians who serve as Legislative Contact Men were briefed January 7 at an IMS seminar. Bulk of the discussion centered on professional liability. Other topics covered included the family practice residency program and radiation control.

1976 HANDBOOK . . . Reports of various committees and councils are being prepared for insertion into this year's Handbook for the House of Delegates. The Handbook will be distributed approximately six weeks before the May 1 and 2 Annual Meeting in Des Moines.

SCIENTIFIC SESSION . . . April 6, 7 and 8 are dates for the 1976 IMS Scientific Session in Iowa City. Broad range of program topics will include prescribing practices, tests not worth doing anymore, care of the sexually assaulted person, acute myocardial attacks, tissue and suture techniques, etc. One day of program will be at University Hospitals. More detailed program will be in the March issue.

MEDICAID FUNDING . . . Budgetary uncertainty continues in the Iowa Medicaid Program. A shortage of $13 million has been forecast by the Department of Social Services. Medicaid Advisory Council, a body of 20 providers, consumers and legislators, met at IMS Headquarters January 14 to assess the situation. Society's Committee on Public Assistance met January 7 to review the problem. IMS will urge a supplemental appropriation, at least to cover the 15,000 additional individuals who have come on the Medicaid roll.

On January 28 the Iowa General Assembly authorized a $13.8 million supplemental amount to avert a Medicaid curtailment.

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IOWA Medical Miscellany

NOMINATING COMMITTEE . . . The 1976 IMS Nominating Committee will meet Sunday, March 28, at Society headquarters. Representatives to the Nominating Committee have been selected in district caucuses. Nominees for 1976-77 will be chosen for president-elect, vice-president, speaker, vice-speaker, trustee (3-year term), AMA delegate (2 to be elected to 2-year terms), AMA alternate delegate (2 to be elected to 2-year terms), councilors (1st, 4th, 6th and 11th districts—3-year terms), and Blue Shield Liaison Delegates to IMS.

HSA BOARD ELECTS . . . New Board of Directors for the Iowa Health Systems Agency (HSA) met February 2 to elect officers. William Kunze, an attorney and consumer representative from Sioux City, was chosen president; John Tyrrell, M.D., Manchester, was named vice-president. Five physicians (4 MD's and 1 DO) are on the 30-member board (17 consumer/13 provider). The physicians are Dr. Tyrrell; Lawrence Ely, M.D., Des Moines; Russell Gerard, M.D., Waterloo; Paul Seebohm, M.D., Iowa City, and Roger Rademacher, D.O., Charles City.

ST. PAUL COVERAGE . . . St. Paul has announced a broadened marketing policy in Iowa for its claims-made coverage. The company will accept application from any Iowa physician (subject to underwriting) for basic limits of $100,000/$300,000 with excess coverage of $1 million. Anesthesiology is limited to the $100,000/$300,000 basic level.

LEGISLATION . . . In addition to professional liability legislation, IMS is involved in proposals which deal with family practice financing, drug product selection, radiation control, the nurse practice act, compulsory immunization, patient bill of rights, provisions for donating body parts, etc.

SUPPLEMENT MEDICAID . . . Curtailment of the Iowa Medicaid program was averted in late January when the Iowa General Assembly passed a $13.8 million supplemental appropriation. The action cancelled a 7-day limit on hospitalization announced earlier by the State Department of Social Services. The additional funding will allow Iowa to maintain present Medicaid services through current fiscal year. IMS reps have met with various lawmakers, the Governor's staff, the Medicaid Advisory Council and others to urge appropriation of necessary supplemental funds.

NO ON JUA . . . Insurance Commissioner Huff ruled February 6 against activating Iowa Joint Underwriting Association. His decision followed a January 28 hearing held to determine need for the JUA. In holding off instigation of the JUA, Commissioner Huff indicated except for one or two instances a professional liability insurance market does exist for Iowa physicians. The two-year JUA was provided for in the H.F. 803 legislation enacted in 1975.

LIABILITY LEGISLATION . . . With report of the Interim Study Committee on Medical Malpractice now distributed, focus is on the House and Senate Commerce Committees where the legislative impetus must come. Legislative possibilities include tightening the role of the Board of Medical Examiners, amendment of Iowa Code to allow for arbitration of future disputes, placing a limit on liability for non-economic loss.

PSRO . . . Iowa Foundation for Medical Care distributed mailing to Iowa hospitals in February inviting formal indication of interest in performing PSRO review activities. IFMC hopes to develop programs with 50 hospitals in coming months.

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IOWA Medical Miscellany

HOUSE OF DELEGATES . . . Physician delegates from county medical societies will be in Des Moines May 1 and 2 for the 1976 House of Delegates sessions. Meetings at Hotel Fort Des Moines will be open to interested IMS members. Session highlights include a talk by Frank Jirka, M.D., member of the AMA Board of Trustees, and an address by Iowa Senator Dick Clark at the delegates' dinner. The House will consider reports from the Society's board of trustees, judicial council and committees, and resolutions from county medical societies. 1976-1977 IMS officers will be elected.

HANDBOOK MAILED . . . Society activities for 1975-76 are summarized in the Delegates' HANDBOOK mailed in March to IMS members who will represent their counties at the annual meeting.

DUES NOTICE . . . Society President Verne Schlaser noted several IMS achievements and involvements in a March letter to Iowa physicians who've not paid 1976 dues. Letter stressed importance of participation and was sent with a final dues statement. 1976 membership response has been good.

PROFESSIONAL LIABILITY . . . Bill number (House File 1489) was assigned to IMS-backed malpractice legislative proposal in early March. Numerical designation follows action by the House Commerce Committee recommending approval. Bill limits to $100,000 loss for non-economic (pain and suffering) reasons, allows for arbitration of future medical disputes, increases disciplinary powers of Board of Medical Examiners, and tightens the contingency fees provisions passed in 1975.

EXECUTIVE COUNCIL . . . IMS Executive Council will have its quarterly session in Iowa City April 6 in conjunction with the Society's 1976 scientific sessions.

MEDICAID STUDY . . . Legislative authorization has been given a $30,000 independent investigation of the Iowa Medicaid Program by Haskins and Sells, a CPA firm. A report is to be made in 90 days after the company evaluates the "significant cost increases, the validity of those costs and the management of the program."

ABORTION MEASURE . . . So-called "conscience clause" legislation received March approval from the General Assembly. The measure precludes discrimination against health care personnel and private facilities who choose not to perform abortion procedures because of religious or other beliefs. Spontaneous or emergency abortions must be attended to by a facility under this new legislation.

PSRO . . . The Iowa Foundation for Medical Care is proceeding with development of PSRO programming with interested Iowa hospitals. Goal is to have working relationships with 50 Iowa hospitals this year.

CLAIMS PROCESSING . . . Blue Shield initiated a new Medicare Part B claims processing system last month. System will allow more rapid processing of claims and will facilitate responses to inquiries. A new Explanation of Medicare Benefits (EOMB) is included to provide summary information for providers. The Summary EOMB's will be generated every Friday and mailed each Monday. Full implementation of the program is expected by April 30.

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IOWA Medical Miscellany

RECEIVE SANDOZ AWARD . . . The JOURNAL OF THE IOWA MEDICAL SOCIETY is one of four medical publications named winners in a national competition conducted by Sandoz Pharmaceuticals. Selected for their appearance and editorial content, each award recipient will receive a plaque and $500. Sandoz officials are to present the IMS its award during the May session of the House of Delegates. Other winners are the Indiana State Medical Association, the Harris County Medical Society (Houston, Texas) and the Medical Society of the County of Monroe (Rochester, N. Y.).

SWINE VIRUS FLU . . . Iowa plans to participate in the nationwide swine flu vaccination program are moving forward. Medical profession support for an Iowa effort was given initially April 6 by the IMS Executive Council, following a report by J. F. Veverka, M.D., chairman of the Society's ad-hoc committee. This committee is working with the State Department of Health on Iowa immunization plans. A further report is scheduled for presentation to the House of Delegates May 1.

MEDICAL LIABILITY . . . Current medical liability conditions were assessed April 15 by the Medico-Legal Committee in a meeting with representatives of the insurance companies and the State Insurance Department. Status report on legislative and other aspects of the medical liability situation is to be presented to the IMS House of Delegates.

SPORTS MEDICINE . . . More than 150 persons attended the 1976 Conference on Medical Aspects of Sports April 8 in Des Moines. The program is a joint effort of the IMS Committee on Sports Medicine and the Iowa High School Athletic Association.

NEW RESIDENCY PROGRAM . . . Five physicians will be first participants in a new residency program in internal medicine scheduled to begin July 1 at the Iowa Methodist Medical Center in Des Moines. Program is a cooperative venture between the Center and the U. of I.

UNIVERSITY EFFORT . . . Recent letter to Iowa physicians from the University of Iowa Medical Center notes stepped-up effort "to strengthen our performance in this all-important arena of community physician relations." Mailing cites a formal statement of "Guiding Principles of Interprofessional Conduct" adopted by all clinical department heads and administrative officials. Distributed as part of the effort is a "Physician's Desk Reference Guide" which contains U. of I. telephone listings and other information to facilitate the communications process. College of Medicine officials reported on this program at the April 6 session of the IMS Executive Council.

MODIFY IMMUNIZATION POLICY . . . On recommendation of the IMS Committee on Maternal and Child Health, the Executive Council April 6 approved Society support of legislation to require certain immunizations as a condition for school entry. A bill (H.F. 1143) is now before the Iowa General Assembly to accomplish this. Heretofore, IMS policy has been that of supporting immunization on a voluntary basis.

PHYSICIAN EXTENDERS . . . The role of the physician's assistant and the family nurse practitioner, as seen by the IMS Committee on Delivery of Health Service, was reported April 6 to the Executive Council. Further consideration of the subject is expected to be undertaken by the House of Delegates.

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IOWA Medical Miscellany

NEW NEWSLETTER . . . Major actions of the 1976 House of Delegates were summarized in early May in IMS UPDATE. IMS UPDATE is new Society communication unveiled at House session. It'll be sent monthly to member physicians and may be distributed more frequently depending on nature and urgency of information to be reported.

HOUSE HIGHLIGHTS . . . In area of professional liability the 1976 House asked for (1) a public education program; (2) investigation and consideration of countersuit activity in selected nonmeritorious liability cases; (3) pursuit of further state legislation to stabilize professional liability; (4) IMS efforts to restore S.F. 1310 to meaningful form in House of Representatives, or, short of that, oppose its passage; (5) further evaluation of excess fund concept; (6) support of hardest-hit specialty groups; (7) liaison with insurance industry in search of group coverage possibilities; and (8) priority attention to data-gathering activity.

OTHER ACTION . . . In other action, House called for (1) continuation of dues at $200 for 1977, with prospects for an increase in 1978; (2) adequate Medicaid funds to provide recipients quality care with provisions for assuring this quality through IMS and the Foundation; (3) deliberations between boards of the IMS and IFMC to develop a memorandum of understanding on policy setting; (4) a tightening of surveillance over multiphasic health screening programs operating in Iowa; (5) commendation of the U. of I. College of Medicine for enhancing intraprofessional communication; (6) approval of the Iowa Swine-like Influenza Immunization Plan with local adaptation possible; (7) development of an IMS position statement on the physician extender; (8) continued physician participation in HSA development; (9) local physician involvement in planning for emergency medical services with IMS support for necessary financial and legislative support; (10) limitation on performance of school physical examinations to MD's and DO's with investigation of legislation to require such an exam; (11) opposition to legislation permitting use of diagnostic or therapeutic drugs by optometrists; (12) retention of IMS JOURNAL with further study of ways to reach the public with information; (13) approval of a Vision Care Indemnity Program through Blue Cross/Blue Shield; (14) consideration of a plan to make physician services available in disaster situations; and (15) consultation with Polk County Medical Society regarding an appropriate memorial to Herman J. Smith, M.D.

NEW OFFICERS . . . J. F. Bishop, M.D., Davenport, became 1976-77 IMS president May 2. Elected or re-elected May 2 were L. W. Swanson, M.D., Mason City, president-elect; A. W. Boone, M.D., Davenport, vice-president; A. J. Havlik, M.D., Tama, trustee; L. D. Caraway, M.D., Amana, speaker; J. H. Lohnes, M.D., Cedar Rapids, vice-speaker; AMA delegates—Erling Larson, M.D., Davenport, J. M. Rhodes, Sr., M.D., Pocahontas, and J. R. Anderson, M.D., Boone; Alternate delegates—C. H. Denser, Jr., M.D., Des Moines, and R. D. Whinery, M.D., Iowa City.

JUDICIAL COUNCIL . . . Re-elected to membership on the Judicial Council were C. L. Kelly, M.D., Charles City; D. M. Youngblade, M.D., Sioux City; A. M. Dolan, M.D., Waterloo; and A. L. Sciortino, M.D., Council Bluffs. Dennis Walter, M.D., Des Moines, was appointed to fill Council vacancy created by resignation of Dr. Denser.

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Fifty Year Club Members

June 1, 1976

Aid, Francis H. ..... Burlington
Anderson, Harold N. ..... Des Moines
Anneberg, Walter A. ..... Carroll

Banton, Oscar H. ..... Charles City
Barnett, Sylvester W. ..... Cedar Falls
Bartlett, George E. ..... New Sharon
Bessmer, William G. ..... Sun City, Arizona
Billingsley, John W. ..... Newton
Block, Charles E. ..... Davenport
Bone, Harold C. ..... Des Moines
Bovenmyer, DeVoe O. ..... Ottumwa
Brereton, Harold L. ..... Emmetsburg
Brinkman, William F. ..... Pocahontas

Carlile, Amos W. ..... Manning
Carstensen, Albert B. ..... Linn Grove
Christensen, John R. ..... Menlo Park, California
Cooper, Gladys A. ..... Plattsburgh, New York
Crawford, Robert H. ..... Burlington

Dahl, Harry W. ..... Des Moines
Dahlbo, John E. ..... Sutherland
Doane, Grace O. ..... Des Moines
Dunn, Francis C. ..... Cedar Rapids
Dyson, James E. ..... Phoenix, Arizona

Felter, Allan G. ..... Van Meter
Fillenwarth, Floyd H. ..... Charles City
Foster, Wayne J. ..... Cedar Rapids
Franchere, Chetwynd M. ..... Mason City
Frank, Owen L. ..... Maquoketa

Gernsey, Merritt ..... Visalia, California
Gibson, Paul E. ..... Des Moines
Gillett, Francis A. ..... Oskaloosa
Gittler, Ludwig ..... Fairfield
Glesne, Otto N. ..... Fort Dodge
Goggin, John G. ..... Ossian
Gottsch, Erwin J. ..... Shenandoah
Grant, John L. ..... Ames

Harper, Harry D. ..... Fort Madison
Harrington, Raymond J. ..... Sioux City
Hill, Lee Forrest ..... Des Moines
Hopkins, David H. ..... Des Moines

Kast, Donald H. ..... Des Moines
Kestel, John L. ..... Waterloo
Kilgore, Benjamin F. ..... Des Moines
Kimball, John E. ..... West Liberty
Kirch, Walter A. ..... Des Moines
Kleinberg, Henry E. ..... Des Moines
Kohrs, Edward F. ..... Davenport
Krigsten, Joseph M. ..... Sioux City

Larimer, Robert N. ..... Sioux City
Leffert, Frank B. ..... Centerville

McBride, Robert H. ..... Sioux City
McMurray, Edward A. ..... Kellogg
Matthey, Carl H. ..... Davenport
Maxwell, Charles T. ..... Sioux City
Maxwell, John, Sr. ..... What Cheer
Miller, Lawrence A. ..... North English
Miltner, Leo J. ..... Davenport
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O'Brien, Stephen A. ..... Mason City

Palmer, Carson W. ..... Guttenberg
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Peterson, Frank R. ..... Cedar Rapids
Phillips, Clarence P. ..... Clear Lake
Piekenbrock, Frank J. ..... Dubuque
Preece, Wade O. ..... Waterloo

Rathe, Herbert W. ..... Waverly
Reuling, Frank H. ..... Waterloo
Richmond, Frank R. ..... Fort Madison
Rock, J. Emmet ..... Bettendorf
Rohwer, Roland T. ..... Sioux City

Saar, Jesse L. ..... Laguna Hills, California
Schnug, George E. ..... Dows
Simmons, Ralph R. ..... Bloomfield, Connecticut
Sohm, Herbert A. ..... Des Moines
Sones, Clement A. ..... Des Moines
Stroy, Herbert E. ..... Osceola
Synhorst, John B. ..... Des Moines

Thompson, Kenneth L. ..... Oakland
Thornton, John W. ..... Lansing
Throckmorton, J. Frederick ..... Des Moines
Trey, Bernard L. ..... Marshalltown

Van Camp, Thomas H. ..... Breda
Victorine, Edward M. ..... Cedar Rapids
Vorisek, Elmer A. ..... Eureka Springs, Arkansas

White, Harold E. ..... Knoxville
Wilson, Fredric L. ..... Eugene, Oregon
Wise, James H. ..... Cherokee

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IOWA Medical Miscellany

MECO PROGRAM . . . Fifty-six hospitals in 48 Iowa communities have participated this summer in the 10-week Medical Education-Community Orientation project. Eighty-nine freshmen medical students have taken part. The seven-year project is a joint effort of the U. of I. Department of Family Practice, The Iowa Chapter of the American Medical Student Association, the Iowa Hospital Association and the IMS.

BROADER RESPONSIBILITY . . . Elmer Smith, M.D., who's been responsible administratively for the services provided under Medicaid, has been given a new and broader designation. He's now medical consultant to the entire Department of Social Services. Charles Ballinger has been named acting chief, Medical Services Section.

PROFESSIONAL LIABILITY . . . Actions of the 1976 House of Delegates which pertain to malpractice were studied in a four-hour session June 23 by the Medico-Legal Committee. Various actions are being implemented and a progress report is to be presented to the Executive Council July 29.

MALPRACTICE PLACARD . . . As of mid-July, requests had been received for more than 400 of the malpractice placards offered by the IMS for office display. The placards contain a brief message regarding the professional liability problem and invite patients to discuss the matter with the physician. Requests for placards are still welcome.

NAMED INSURANCE COMMISSIONER . . . Herbert W. Anderson was named in June to succeed William Huff as Iowa Insurance Commissioner. Anderson has been Deputy Insurance Commissioner since joining the Department in 1971.

IOWA MEDICAID . . . The current Medicaid appropriation of $50 million is now being used to pay for services provided Iowa Title XIX participants. Officials of the Department of Social Services estimate this sum will be about $9 million short of the actual need. Any curtailment in the program to meet fiscal limitations will await findings of a current study by Haskins and Sells, a private CPA firm. The final report is expected in late August.

BID FOR COUNCIL . . . Nominated by the AMA Board of Trustees, L. W. Swanson, M.D., Mason City, the Society's president-elect and a former AMA delegate, lost a bid for membership on the AMA Council on Constitution and By-Laws. He was one of four candidates for a single position.

APPROVE CRITERIA . . . Criteria for guideline use in the provision of inpatient psychiatric care was approved at a July 14 meeting of the IMS Committee on Psychiatric Care. Representatives of the Committee have been working closely with the Iowa Foundation for Medical Care in the updating of these standards.

SITE CHOSEN . . . As reported by Society President J. F. Bishop, M.D., in this issue, the 1977 IMS Scientific Sessions will be held at Telemark Lodge in Cable, Wisconsin, from July 10 to 15.

SOCIETY REQUEST . . . A recent letter from Society President Bishop to Health Commissioner Norm Pawlewski requested formal clarification on liability aspects of the A/New Jersey influenza immunization project. With the cooperation of the Commissioner, the issue is being reviewed.

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IOWA Medical Miscellany

SWINE FLU PROJECT . . . As this is prepared, President Ford has just signed federal legislation clearing liability obstacles faced by the A/New Jersey vaccine manufacturers. With this development, State Department of Health officials indicate vaccine will probably reach Iowa by late September with subsequent distribution to the county and community level in October. An IMS informational mailing containing the July opinion of the Iowa Attorney General regarding liability was sent in mid-August to county society presidents and secretaries. More information on the vaccine appears on Page 367 of this issue.

MERCY HOSPITAL RECOGNIZED . . . Des Moines' Mercy Hospital is the first Iowa facility to have its continuing medical education activities accredited under the cooperative program instituted by the Iowa Medical Society and the American Medical Association. Mercy officials received a framed certificate attesting to this accreditation at the July 29 session of the IMS Executive Council. Participants in Mercy CME programs now become eligible for Category I credit toward the AMA Physician's Recognition Award. Other Iowa facilities and organizations are invited to contact the IMS for info on the program.

PROFESSIONAL LIABILITY . . . Medical liability report was submitted July 29 by the IMS Medico-Legal Committee to the Executive Council. Among other things, the Council approved various measures recommended by the M-L Committee for inclusion in a 1977 legislative program. The measures include legislation (1) to further assure quality care through additional responsibility to Board of Medical Examiners, (2) to allow for periodic payment of large damage awards, (3) to place a limit on pain and suffering awards, (4) to add a new definition of the standard of medical care in determining negligence, and (5) to permit arbitration of future disputes.

IMS EXCESS MAJOR MEDICAL . . . Approval was given July 29 by the Executive Council to a new underwriter for the Excess Major Medical coverage which is available to IMS members. The Insurance Company of North America has agreed to offer the coverage with rates and benefits equivalent to the previous program with one or two additional options. Approximately 110 Iowa physicians are participants in the program which is administered for the IMS by the Prouty Company of Des Moines.

FORWARD OBESITY GUIDELINES . . . At its July 29 session, the IMS Executive Council received proposed new Guidelines for Treatment of Morbid Obesity from the Society's Committee on Medical Service. The Council declined taking specific action on the guidelines other than to transmit them to the Iowa Foundation for Medical Care.

CME REQUIRED . . . The Executive Council referred to the IMS Committee on Medical Education and Hospitals a recommendation of the Medico-Legal Committee that physicians be required to complete a specified amount of CME as a condition of license renewal or maintenance of Society membership.

BLUE SHIELD ELECTS . . . The following Iowa physicians have been elected or re-elected to the Blue Shield Board of Directors: J. M. Rhodes, Sr., M.D., Pocahontas; R. A. Sautter, M.D., Mount Vernon; J. R. Anderson, M.D., Boone; A. H. Downing, M.D., Des Moines, and J. F. Veverka, M.D., Prairie City. Charles Denniston of Newton was elected a new lay member of the Board. Following officers were re-elected: C. E. Radcliffe, M.D., chairman; E. E. Linder, M.D., president; J. D. Ver Steeg, M.D., secretary; Locke Macomber, treasurer; R. C. Larimer, M.D., first vice-president, and Dr. Rhodes, second vice-president.

(More Miscellany on pages 371 and 382)

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IOWA Medical Miscellany

FALL CONFERENCE FOR COUNTY OFFICERS . . . October 28 is an important date on the 1976 IMS calendar. On that Thursday is scheduled the Conference for County Society Presidents (or their designees). The day-long meeting will be at Society Headquarters in West Des Moines. The conference will include briefings on professional liability, health planning, continuing education, national legislative developments, etc. Counties are urged to have one or more representatives present.

MEDICAID STATUS . . . Expectations are the State Department of Social Services will maintain its present level of benefits for Medicaid recipients even though doing so will produce an anticipated $9 million deficit. This status quo action of the DSS is based on sentiment expressed in support of a supplemental appropriation by a legislative interim committee. Earlier curtailments proposed by Social Services Commissioner Kevin Burns included a 10-day limit on Medicaid hospitalization. Uncertainty will persist for a time.

MEDICAID FRAUD . . . The time has come to crack down—and crack down hard—on Medicaid fraud and abuse. So said J. H. Sammons, M.D., executive vice-president of the AMA in a late August statement. He cited language approved by the 1976 AMA House of Delegates: "The AMA condemns and deplores all acts of fraud and wrongdoing, including in particular any wrongful acts as recently reported in the Medicaid and Medicare programs. We urge that responsible government agencies proceed with all due speed in the prosecution under the provisions of due legal process of all who are charged with guilt of fraudulent misconduct. We will continue to offer our cooperation and assistance in bringing to an end such activities."

CME MATTERS . . . Moving forward expectantly from its July 26 receipt of a full four-year approval from the AMA, the IMS Committee on Medical Education and Hospitals met September 1 to continue its continuing medical education accreditation activities. The Committee has a further CME site survey scheduled and is evaluating several pre-survey applications.

HSA ACTIVITY . . . Organizational activities of the Health Systems Agency are continuing. In addition to its Des Moines headquarters, the Iowa HSA has opened sub-area offices as follows: Area 1—Charles City (Peter Brown, Assistant Director); Area 2—Cherokee (Karen Waldschmitt, Assistant Director); Area 3—Carroll (Ray Rabe, Assistant Director); Area 4—Des Moines (Bill Miles, Assistant Director); Area 5—Oakdale (Assistant Director to be named).

IOWA HEALTH COUNCIL . . . Annual meeting of the Iowa Health Council occurred September 21 in Des Moines with A. L. Schluter, Lake View, named president. Mr. Schluter represents the Health Facilities Association of Iowa. Eldon Huston, IMS executive vice-president, was re-elected secretary treasurer.

POISON CONFERENCE . . . The Second Annual Iowa Poison Information Seminar will be October 15 at the Iowa Methodist Medical Center in Des Moines. Registration is $25. Faculty includes Jay Arena, M.D., Professor of Pediatrics, Duke University; Anthony Temple, M.D., Director, Intermountain Regional Poison Control Center; Page Hudson, M.D., Chief Medical Examiner, State of North Carolina; Donal Morgan, M.D., Director, Institute of Agricultural Medicine, Oakdale; Robert Roberts, Professor of Pediatrics, University of Iowa, and Mark Thoman, M.D., Medical Director, Iowa Poison Information Center.

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IOWA Medical Miscellany

THIRD INTERIM MEETING . . . The Iowa General Assembly's interim committee studying the broad aspects of professional, products and public liability will have its third meeting November 10. The second session (October 5 and 6) included an IMS presentation which set forth certain legislative recommendations and provided economic information on physicians as requested by the Committee. A presentation was also made by the president-elect of the Iowa Society of Anesthesiologists. No clear indication exists as to what type of report the Committee will present to the 1977 Assembly.

DUES STATEMENTS MAILED . . . 1977 dues statements will be mailed in November to Iowa physicians. Now going into its seventh year, the IMS dues billing service is used by 84 of the 93 county medical societies. Under this system, county, IMS and AMA dues are collected by the IMS; income and membership reports are then transmitted by the IMS to the participating county societies.

PSRO PROGRESS . . . October has seen additional Iowa hospitals receive "delegated status" from the Iowa Foundation for Medical Care. Nineteen hospitals now have been approved for this PSRO designation which means they are able essentially to carry on independent local review of Medicare and Medicaid patients with periodic assessment by the Foundation. The Foundation's Hospital Evaluation Committee is now conducting site visits to 10 additional hospitals.

LCM SEMINARS . . . A series of six meetings for IMS legislative contact men (LCM's) will occur around the state between November 9 and 18. These briefings will cover the election results and the medical issues likely to receive attention in 1977.

INSURANCE SUMMARY . . . Included in this issue is a summary of those insurance coverages available to member physicians through the Iowa Medical Society. See pages 455 to 458.

COUNTERSUIT FILED . . . A Cedar Rapids orthopedic surgeon filed a $250,000 mid-September suit against two Missouri residents and their attorney. The suit is the aftermath of an earlier action which the now defendants (plaintiffs in the earlier precipitating case) charged careless treatment. The initial suit (against the physician) was dismissed when no negligence was proved. While not stimulated by the Society, this litigation is responsive to an action of the 1976 IMS House of Delegates which urged evaluation and possible action in the area of legal counteraction.

DELEGATES PARTICIPATE . . . Two IMS delegates have been assigned responsibilities at the 1976 AMA Clinical Meeting December 4-7 in Philadelphia. John R. Anderson, M.D., Boone, will serve on the Credentials Committee, and John M. Rhodes, Sr., M.D., Pocahontas, will serve on the Committee on Rules and Order of Business. Iowa has three delegates to AMA House of Delegates.

MANPOWER INVOLVEMENT . . . The IMS has agreed to participate in the development of a Health Personnel Information Services System. The project is being spearheaded by the State Office for Planning and Programming. The program will seek to exist as an information clearinghouse for health care personnel seeking work opportunities and will also assist Iowa communities recruiting personnel. IMS involvement is to June 30, 1977, at which time an evaluation will be made as to the worth of the project.

(More miscellany on page 454)

THE JOURNAL OF THE IOWA MEDICAL SOCIETY

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IOWA Medical Miscellany

'77 ASSEMBLY . . . The Society's 1977 legislative planning began moving forward in earnest in early October with a meeting of the Society's Committee on Legislation. Six regional briefings have followed in November for IMS Legislative Contact Men (LCM's) and other interested physicians. Purpose of these briefings has been to review the health-related issues likely to emerge in 1977 and to evaluate the results of the November elections. The regional confabs occurred in Davenport, Storm Lake, Atlantic, Hampton, Monticello and West Des Moines. Further strategy will be devised prior to the January 10 opening of the General Assembly.

LEGISLATIVE ISSUES . . . Topics before the '77 General Assembly are likely to be familiar ones, e.g., funding for the family practice residency program, Medicaid appropriations and professional liability. Other measures which may receive attention include compulsory immunization, certificate of need, use of diagnostic drugs by optometrists, corporate practice of medicine, ownership of records, control of blood, patients' rights and chiropractic expansion.

SWINE FLU . . . Participation by Iowans in the swine flu vaccination program has been most gratifying, according to reports from the State Department of Health. The SDH has sought to move vaccine on to waiting counties as rapidly as possible after its receipt in Des Moines. The SDH has asked help from Iowa physicians who have requested vaccine for office use. The SDH is obliged to submit information on number of doses, age of recipients, etc. It is hoped physicians will return the tally sheets with the information which is requested.

NEW TELEPHONE . . . IMS Headquarters has been assigned a new telephone number. Calls should now be made to 515/223-1401.

PROFESSIONAL LIABILITY . . . Society participation is continuing in the sessions of the Legislative Interim Study Committee on Liability. Most recent meeting occurred November 10. Availability and cost of excess coverage remain the matters of greatest concern. Various Iowa physicians (particularly those having basic coverage with Medical Protective) report receiving non-renewal notices from their excess carriers; MP has maximum limits of $200,000/$600,000. As of now, physicians with St. Paul and Aetna are able to obtain the higher limits coverage; St. Paul, with its claims-made coverage, has added approximately 180 Iowa physicians to its fold this year.

AETNA OFFER . . . A December 1 letter to Society members from President Bishop disclosed an invitation from the Aetna Life & Casualty to consider an IMS-sponsored professional liability insurance program. Dr. Bishop's letter was accompanied by a questionnaire seeking to measure member interest in the proposal. Presumably, a recommendation will be considered by the Executive Council in January.

IFMC ACTIVITY . . . Formal PSRO relationships with 50 Iowa hospitals is the January 1 goal of the Iowa Foundation for Medical Care. Signing of memoranda of understanding with approved hospitals has been progressing at the rate of 3 to 6 a week. By early November hospitals representing 48% of the state's admissions were affiliated with the PSRO program.

IMS HEALTH COVERAGE . . . A November memorandum to Society members advises of a January 1 rate increase in the Statewide Physicians Health Program which is offered through Blue Cross/Blue Shield. There are 641 active contracts under the program which includes two coverage options.

respond to one

According to her major
ptoms, she is a psychoneu-
c patient with severe
iety. But according to the
cription she gives of her
ings, part of the problem
/ sound like depression.
s is because her problem,
ough primarily one of ex-
ive anxiety, is often accom-
ied by depressive symptom-
ogy. Valium (diazepam)
provide relief for both—as
excessive anxiety is re-
ed, the depressive symp-
s associated with it are also
n relieved.

There are other advan-
es in using Valium for the
nagement of psychoneu-
c anxiety with secondary
ressive symptoms: the
chotherapeutic effect of
ium is pronounced and
id. This means that im-
vement is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

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in psychoneurotic
anxiety states
with associated
depressive symptoms

veillance because of their predisposi-
to habituation and dependence. In
gnancy, lactation or women of child-
ring age, weigh potential benefit
inst possible hazard.

cautions: If combined with other psy-
tropics or anticonvulsants, consider
efully pharmacology of agents em-
/ed; drugs such as phenothiazines,
cotics, barbiturates, MAO inhibitors
other antidepressants may potentiate
action. Usual precautions indicated in
ients severely depressed, or with latent
ression, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

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Nutley, New Jersey 07110

President's Page

Health planning is the name of the tune at the moment. And it's taken on a staccato beat. What we have in process right now is the important selection of Iowans to guide broadened federal health planning mandates which have been imposed. Those who are chosen to lead this activity will have a significant impact on tomorrow's health care delivery.

We refer to the Iowa Health Systems Agency (HSA). For much of the past year, we've been devoting considerable time to the ramifications of this program. It is the offspring of the Health Planning and Resources Development Act of 1974 (P.L. 93-641), and it involves 90 of the 99 counties (plus one Nebraska county).

As this is prepared, a complex nomination and selection process is unfolding. It is identifying those who will serve on the 30-member HSA Board of Directors and the five sub-area advisory councils.

As has been communicated to the leadership of the county medical societies, the concern of the Iowa Medical Society is that there be adequate representation from the medical profession in this new health planning venture. We have encouraged physician involvement in the local determination of the 30-member HSA Board and the sub-area councils (both provider and consumer). Moreover, the IMS has submitted candidates for election as at-large members of the HSA Board.

By the time this is read it is likely much of the HSA leadership will have been determined. We hope the electors will have acted wisely. We hope that an adequate representation will have been chosen from the medical profession. We hope too that Iowa physicians will recognize the significance of this program and will seek to understand its various aspects.

Sincerely,

V. L. Schlaser MD

V. L. Schlaser, President

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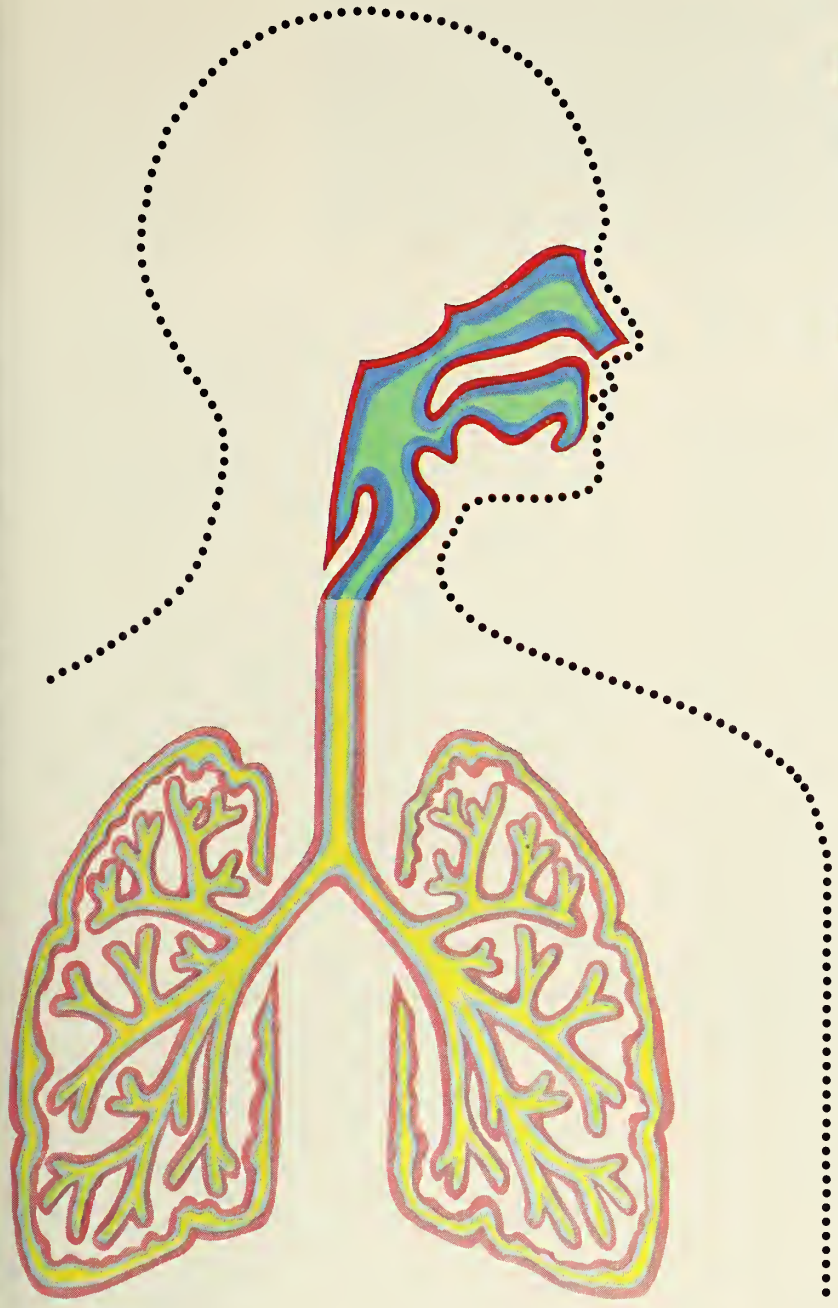
Cold/Allergy and Cough Country



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CONTRAINDICATIONS: RYNATAN is contraindicated in those patients who are sensitive to sympathomimetic drugs.

PRECAUTIONS: Use with caution in patients with hypertension, hyperthyroidism, diabetes or coronary artery disease: warn of possible drowsiness in patients who may operate vehicles or machinery.

AOVERSE REACTIONS. Drowsiness and dryness of the mouth are occasionally associated with antihistamine therapy in some individuals.

OOSAGE AND ADMINISTRATIDN: RYNATAN TABLETS: 1 or 2 tablets every 12 hours.

RYNATAN PEDIATRIC SUSPENSION: For children over six years of age, 5 to 10 ml. (1 to 2 teaspoonfuls) every 12 hours: for children two to six years of age, 2.5 to 5 ml. (½ to 1 teaspoonful) every 12 hours; for children under two years of age, 1.7 ml. (⅓ teaspoonful) every 12 hours.

CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

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INDICATIONS: In the treatment of coughs due to the common cold, asthma, and in acute and chronic bronchitis.

CONTRAINDICATIONS: RYNATUSS is contraindicated in those patients who are sensitive to sympathomimetic drugs.

PRECAUTIONS: Use with caution in patients with hypertension, hyperthyroidism, diabetes or coronary artery disease: warn of possible drowsiness in patients who may operate vehicles or machinery

ADVERSE REACTIONS: Drowsiness and dryness of the mouth are occasionally associated with antihistamine therapy in some individuals.

DOSAGE ANO ADMINISTRATION:
RYNATUSS TABLETS: Adults—1 to 2 tablets every 12 hours.

RYNATUSS PEDIATRIC SUSPENSION: For children over six years of age, 5 to 10 ml. (1 to 2 teaspoonfuls) every 12 hours: for children two to six years of age, 2.5 to 5 ml. (½ to 1 teaspoonful) every 12 hours; for children under two years of age, 1.7 ml. (⅓ teaspoonful) every 12 hours.

CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

The above represents a brief summary. See package inserts for full prescribing information.

Refresher Course for the Family Practitioner

The 1976 Refresher Course for the Family Practitioner will occur in Iowa City February 17 to 20 under sponsorship of The University of Iowa College of Medicine and the Iowa Academy of Family Physicians.

The course is accredited for 26 hours by the American Academy of Family Physicians and for Category I credit toward the AMA Physicians' Recognition Award. Full information is available from the Office of Continuing Medical Education, U. of I. College of Medicine, Iowa City, Iowa 52242.

If you plan to arrive on Monday, February 16, a limited number of tickets have been reserved for the Iowa-Northwestern basketball game. The University Symphonic Band will be performing at Hancher Auditorium on February 18 and the Netherlands Wind Ensemble on February 19.

Topics to be considered on the following three days include:

TUESDAY, FEBRUARY 17

Immunizations—How, When, and Why
The New Antibiotics
The Hazards in Prescribing Psychotropic Agents
Lower GI Bleeding in Infants and Children
Radiographic Examination of the Breast
Have We Seen the End of Rh Troubles?
Skin Problems of the Aging Person
Athletic Medicine (Man vs. Ball)
Issues in Medical Ethics
The Hard of Hearing Child
Indications and Complications of Joint Replacements
Gynecologic Endocrine Problems
Host Resistance: Progress in Treating Childhood Cancers
Evaluation and Management of Sub-Arachnoid Hemorrhage
Questions and Answers on Skin Problems
Surgical Problems of the Umbilicus in Infants and Children
Proper Care for Hand Injuries
Successful Approach to the Adolescent Patient
LaMaze Method of Prepared Childbirth
Individual Check-out for Cardio-Pulmonary Resuscitation
Myringotomy and Insertion of Polyethylene Tubes
Common Ocular Problems in Children
Pre-Op Evaluations—What Really Counts?
Giving Better Help to Patients with Cancer

WEDNESDAY, FEBRUARY 18

Can a Fat Hypertensive Smoker Beat the Risk Factors?
Skills in Marriage and Family Counseling
Help for Hangups—The Difficult Delivery
Acid-Base Balance
Unusual Presentations of Fractures in Radiographs
Landmark Legal Cases That Have Shaped Medical Practice
Sexual Activity in the Aging Male
Pre-natal Screening of Chromosomes—Who? When? Why?
The Nurse Practitioner
Proper Use of Blood Gas Determination
Office Orthopedics
Cardiac Auscultation Workshop
Evaluation of Urinary Tract Infection
Genetic Counselling

THURSDAY, FEBRUARY 19

Thyroid Today—An Endocrine Update
More Effective Control for Epilepsy Patients
How to Establish the Cause of Anemia
Rational Approach to the Child with Asthma
Taking Board Exams in Family Practice—Original or Recertification
Problems of Antibiotic Toxicity
Evaluation of Pelvic Mass
Personnel Management: Hiring and Firing
Inserting a Chest Tube
Reducing Nasal Fractures
What to Do When the Pap Smear Is Positive
Blunt Trauma to the Chest
Are Problem-Oriented Records Worthwhile?
Assessing the Risk of Suicide
Foreign Bodies of the Ear, Nose and Throat
Assessing the Patient with Chronic or Recurrent Infection
Status of the New Laws Regarding Involuntary Commitment
Hypertensive Drug Management
Reading EKG's—Self-Assessment and Consultation
Diabetes
Diagnosing and Treating Obstructive Vascular Disease in the Lower Extremities

FRIDAY, FEBRUARY 20

Morbidity and Mortality after Surgery in the Aged
Zoonotic Disease of Occupational Significance in the Midwest
Behavioral Management of Children's Learning and Behavior
Proper Investigation of Scrotal Masses
Management of Headaches in Children
Better Help for Alcoholic Patients
Is Your Recovery Room Up-to-Date?
Health Versus Medicine
Neonatal Care in Your Locale
What Screening Procedures Should Be Done in Office Practice?
Cardiology Today
What's New in Non-Invasive Diagnostic Procedures?
What's New in Drug Therapy for Ischemic Heart Disease?
What's the Status of Surgery for Ischemic Heart Disease?

Educationally Speaking

by RICHARD M. CAPLAN, M.D.

ON BECOMING A STUDENT AGAIN

Today in Ohio, I and others from the University of Iowa College of Medicine conducted a workshop on How to Evaluate Projects in Cancer Education. Those attending were senior faculty members from colleges of medicine and dentistry over the nation. Each of those individuals carries responsibility for conducting educational programs about cancer at his/her academic home. Teachers of medicine and dentistry seldom have formal training in the theory and methods of education. Instead, they tend to fly by the seat of their pants, imitating what was done by their own teachers, and occasionally innovating as the spirit moves them. The logic and methods for formal evaluation therefore were new to most of the workshop participants. Some new words and definitions appeared and a few old words were used in new ways. A systematic approach to step-by-step planning was introduced. Several of the participants showed much furrowing of the brow and dark looks. One later confided to me that "some of us felt uncomfortable with this new material because it made us feel like students again."

Why would a surgeon, who can plan a step-by-step procedure to successfully remove a cancer-laden descending colon, who would not think of approaching his task in any but a carefully ordered method, find it difficult to grasp the idea of developing a step-by-step plan to achieve an educational goal? Why would a full-time academician express pain at being trapped in the guise of a student? Should not teachers, *especially* teachers, be particularly given to experience the pleasure, the up-beat lift of learning something new? Of course they should, but this is not an ideal world. What might keep them in such a state of discomfort? Possible statements to account for this attitude include:

a) If you're a professor, you already know everything.

b) If you're a student, you're a dummy.

c) To say "I don't know" exposes one as inadequate.

d) If I'm a grown person, I should have learned this when I was young.

e) If I'm a teacher, or paid to be one, I presumably would know this already.

f) The ability to educate or instruct others is intuitive or in-born, and attempts to "learn" it must by definition be wasteful.

g) In my "student days" learning was always such a chore and associated with so much unpleasant pressure that any reversion to that posture re-ignites all the old distresses.

h) This kind of planning effort costs time and trouble and I'm already too busy, unless you can prove to me that it pays off.

i) There must surely be others. . . .

The harder it is to say "I don't know," or the harder it is to express curiosity, then the harder it will be to take the role of student. "I don't know" followed by, "But I'd like to try to find out" ought never to be considered degrading or unprofessional. On the contrary, it is one of the clearest markers of a mature physician who is concerned about his own growth and his patient's well being.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

INTESTINAL PARASITES AMONG INDOCHINESE REFUGEES

Infestation by intestinal parasites has been reported to the State Department of Health by several physicians and public health nurses who have been involved in the care of Indochinese refugee families recently arrived in Iowa. Such observations seem to have been common across the country, and have apparently raised questions about the public health significance of intestinal parasites carried by this group of persons. The U. S. Center for Disease Control conducted a survey to determine the rates of parasitic infestation among Indochinese refugees in an effort to provide some information upon which to make a reasonable judgement on this question. The results of the survey, coupled with a knowledge of the life cycle of the various parasites, suggests that intestinal parasitic infestation in this group of persons is not a cause for public health concern in this country. The CDC report and recommendations were published in the Morbidity and Mortality Weekly Report of November 22, 1975, and are reprinted here.

SURVEY OF VIETNAMESE REFUGEE CENTERS FOR INTESTINAL PARASITES

Random surveys of Vietnamese refugees at 3 American sites suggest that the refugees' intestinal parasites do not pose a public health risk to the U. S. population.

The refugees, centered in Indiantown Gap, Pennsylvania, Fort Chaffee, Arkansas, and Camp Pendleton, California, were surveyed between September 2 and 18, 1975, in a random fashion within each of 3 age groups: 1-5 years, 6-12 years, and 13 years and over. Single stool samples were obtained from 1,077 of 48,340 refugees, and preserved in 2 media—5% formalin and polyvinyl alcohol. All specimens were examined at CDC in

(Please turn to page 23)

TABLE I

PREVALENCE OF INTESTINAL PARASITISM IN THE VIETNAMESE REFUGEE CENTERS—SEPTEMBER 1975

	Protozoan		*Helminths*			
	E. histolytica	*Giardia*	*Ascaris*	*Trichuris*	*Hookworm*	*Strongyloides*
Location	%	%	%	%	%	%
Fort Chaffee ..... n = 317	2.7	11.6	28.5	6.5	3.5	0.4
Indiantown Gap ..... n = 470	1.9	5.0	33.8	13.2	12.7	1.4
Camp Pendleton ..... n = 290	0.9	4.1	32.3	11.3	0.9	2.4
Total ..... n = 1077	2.0	8.2	30.5	9.0	4.1	1.2

Source: Morbidity and Mortality Weekly Report, Vol. 24, No. 47.

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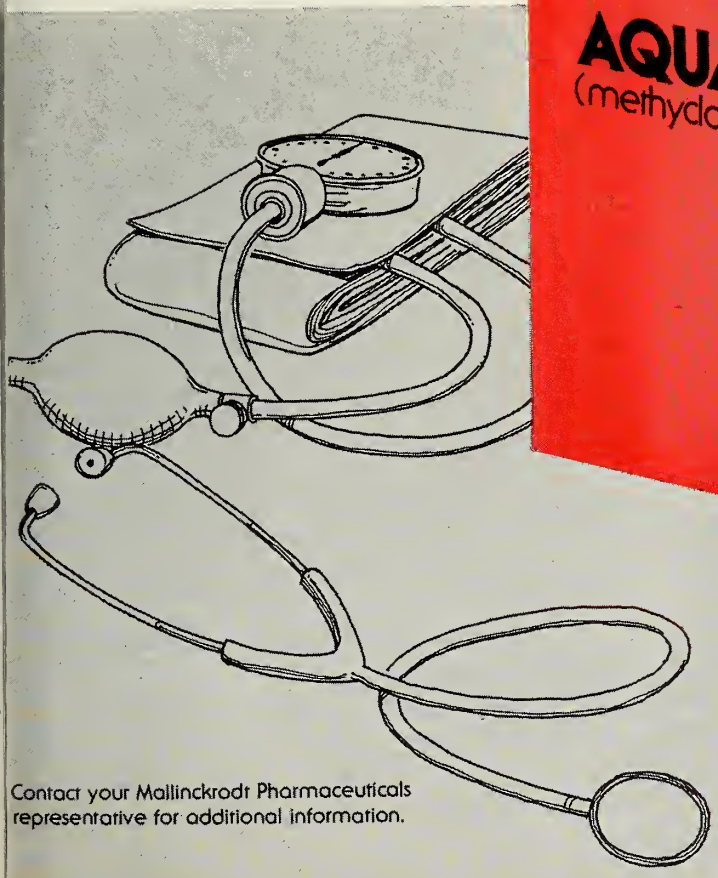

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IFMC REACHES AGREEMENT ON PSRO CONTRACT

LAST MONTH the Iowa Foundation for Medical Care (IFMC) took a major step toward operational status as the state's Professional Standards Review Organization (PSRO). On December 15, the IFMC agreed to a conditional PSRO contract with the Department of Health, Education and Welfare.

The December culmination of PSRO contract negotiations prompts this inquiry: *What is in store for Iowa in 1976?*

Before addressing this question however a brief review comment on PSRO may be helpful. The PSRO program was established in 1972 as part of Public Law 92-603. It is to be organized, directed and administered by physicians. It must evaluate the necessity and quality of medical care delivered to individuals in the Medicare, Medicaid and Maternal and Child Health programs.

A word about the IFMC may also be useful before any comments on 1976 plans for PSRO in Iowa. The Foundation was created in 1971 by Iowa physicians to assure quality care (1) in appropriate amount, (2) at reasonable cost, and (3) within reasonable distance.

Since 1972, insofar as Iowa is concerned, PSRO has withstood most or all of the preliminary tests. Designation of Iowa as a statewide PSRO occurred in 1974. This was followed by word from HEW of its intention to name the Foundation as Iowa PSRO. A planning grant was then awarded to the IFMC. Last summer Iowa physicians were polled to ascertain the profession's acceptance of the Foundation as the Iowa PSRO. With this hurdle cleared, contractual negotiations proceeded from September to early December.

In 1976, in accordance with its approved PSRO blueprint, the Foundation expects to enter into agreements with selected short-stay hospitals. These agreements will give local physicians the go-ahead to measure the necessity and appropriateness of their in-hospital medical care. In the main, the individual PSRO programs will have been devised by the hospital medical staffs, with subsequent endorsement from and review by the IFMC. Thus, the Foundation will rely heavily on the efforts and expertise of physicians in their capacities as members of hospital medical staffs.

In the implementation of the PSRO program, the Foundation hopes to build as extensively as possible on its private peer review structure. This well-established structure functions on a dispersed basis with district committees and other mechanisms. Extensive non-PSRO peer review has occurred via this organizational arrangement during the Foundation's four-year existence.

Under the PSRO law, the hospital performing effective review will have what is called "delegated status." The hospital achieving this designation will have presented an acceptable local plan for performing PSRO review activities. Such a designation will entitle the hospital to submit Medicare, Medicaid, etc., claims to the fiscal intermediary (Blue Cross/Blue Shield) and be free of any follow-up review of care as to its necessity or duration. IFMC committees will have responsibility for assuring that the "delegated" hospitals maintain efficient review programs.

It is believed the Foundation will have resources sufficient to develop relationships with approximately 50 Iowa hospitals in 1976. Most of these, it is hoped, will seek and achieve the "delegated status." If this level of participation is reached it will mean that about one-third of Iowa's 150 hospitals will be phased into PSRO.

In its planning activity, the Foundation surveyed all Iowa hospitals to determine medical staff interest in accepting PSRO review responsibilities. This survey helped the IFMC gain insight into the PSRO preparedness of Iowa hospitals. The majority of the respondents were willing to accept review responsibility.

It's obvious the activities anticipated in 1976 will represent the plowing of new ground. There is bound to be some uncertain terrain. But the planning which has occurred should minimize this. As the program becomes operational, it should be re-emphasized that PSRO is a physician effort—even though governmentally mandated—to assure topflight health care for patients involved.

IN THE PUBLIC INTEREST

SCIENTIFIC ARTICLES

Suprapubic Aspiration of Urine in Neonate

S. SAHU, M.D.
Des Moines

The indications and the technique of suprapubic aspiration of bladder for obtaining a urine specimen in neonates are described. Relevant literature is reviewed to indicate it is a simple, safe and easy procedure to be done in neonates and children.

THE NEWBORN INFANT is the only patient who leaves the hospital without having had urine studies done routinely. Physicians in general do not think in terms of presence of bacteriuria in normal newborns and prematures (pre-term infants) and do not usually order the necessary tests. Part of the failure undoubtedly relates to the difficulty with the collection of suitable specimen in the nursery. Uncertain patient compliance (voiding), fecal soiling, faulty urine collectors, difficulty in fixing the collector, and contamination of the specimen with urethral or fecal flora further complicate the situation.

Premortem diagnosis of urinary tract infection is frequently missed in the neonatal period and infancy. Neumann *et al*[1] reported the autopsy experience of a large city hospital, where only 17% of the infants with postmortem evidence of active acute and chronic pyelonephritis had had such diagnosis entertained during life. Collection of uncontaminated urine in the newborn infant is quite difficult. The reliability of a catheterized specimen, particularly in a neonate, is no greater than clean voided specimen, particularly for bacteriologic evaluation. 7% to 30% of clean-voided specimens from normal, healthy newborns will contain bacteria over 100,000 per ml. In a recent study (1973) Edelmann *et al*[2] analyzed clean-voided urine obtained from 836 full-term newborns and 206 pre-term infants, and found the following. (See Table I.)

TABLE I

Bacterial Count Per ml	*Full-Term Infants Total No. 836 (M:F 384:452) Percentage*	*Pre-Term Infants Total No. 206 (M:F 109:97) Percentage*
No growth	77.6 (649)	49.0 (101)
10-10^3	9.4 (79)	11.6 (24)
10^3-10^4	7.1 (59)	19.4 (40)
10^4-10^5	3.9 (33)	12.6 (26)
$\geq 10^5$	1.9 (16)	7.3 (15)
	100% (836)	100% (206)

Thus (49/836) 5.9% of full-term infants and about 20% (41/206 of pre-term infants had significant bacteriuria ($> 10^4$ per-ml.) on clean-voided urine examination. Bacteriuria was ruled out in every full-term infant with an initially

Dr. Sahu is Director of Nurseries at Mercy Hospital, Des Moines, Iowa. He is also assistant professor of pediatrics at the College of Osteopathic Medicine and Surgery.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF JANUARY, 1976.

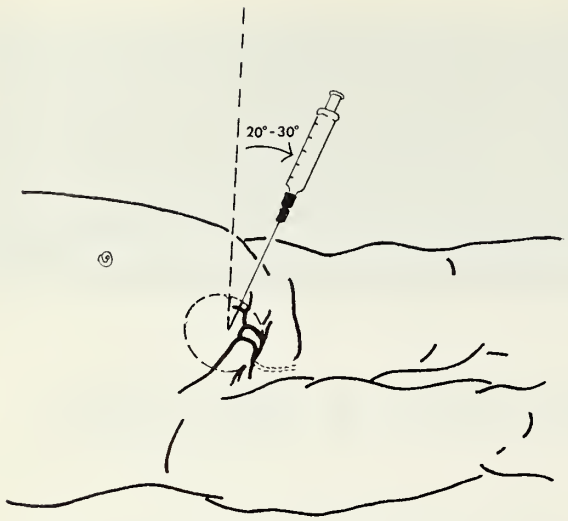

Illustration No. 1

positive result who was reexamined by means of suprapubic puncture. Significant bacteriuria was present in 3.4% of pre-term infants on suprapubic urine cultures. Pendarvis and associates,[3] using suprapubic puncture, found bacteriuria in 9.8% (10/102) of pre-term infants. Zies and associates[4] found 5.6% (3/54) incidence of bacteriuria in premature infants as determined by suprapubic aspiration.

In 1956, Guze and Beeson[5] published the first report of the use of bladder puncture for bacteriologic study of urine in four gynecological patients. In 1959, Pryles[6] pioneered the procedure in children, and Nelson,[7] in 1965, used the procedure in neonates for the first time.

THE NEED FOR SUPRAPUBIC BLADDER ASPIRATION IN NEONATES

1. The difficulty and unpredictability of obtaining uncontaminated urine specimen in neonates.
2. Catheterization is difficult and hazardous from the standpoint of initiating infection in the bladder.
3. It is a safe, easy, quick and useful method of obtaining urine for an accurate diagnosis of urinary tract infection prior to antibiotics therapy.

INDICATIONS FOR SUPRAPUBIC BLADDER ASPIRATION

1. As a part of sepsis work up in term and preterm infants before starting antibiotics.
2. Any urine culture obtained by clean voided method
   a. and growing gram negative organisms.
   b. and growing more than 10^4 colonies per ml of urine.
   c. and growing multiple organisms.
3. To save time, in all preterms, and severely ill newborns, the initial urine culture should be by suprapubic aspiration.

TECHNIQUE OF SUPRAPUBIC NEEDLE ASPIRATION OF BLADDER IN NEONATES (SEE ILLUSTRATION I.)

It is easier to do a suprapubic bladder puncture in neonates than older children, because the bladder in neonates is high in the pelvis and extends above the symphysis pubis even when small amounts of urine are present. The main prerequisite for a successful procedure is a dry diaper. If the baby has voided shortly before, it should be fed some extra formula or water and the procedure delayed 40 to 60 minutes.

Materials Required: Antiseptic solution, 1½ inch 21 or 22 gauge needle, 5 or 10 cc syringe.

1. The neonate is placed on a flat surface and is immobilized in frog leg position by an assistant who holds the lower thorax with one hand and thighs and hips with the other.
2. To avoid reflex voiding, the male urethra is compressed by pressure on the penis, and the female urethra is compressed by pressure through the rectum (not always necessary).
3. The skin between the symphysis pubis and the umbilicus is cleaned well with antiseptics (Betadine, or alcohol).
4. An all-metal 21 or 22 gauge 1½ inch (3.8 cm) short beveled needle is attached to a 5 or 10 cc disposable syringe.
5. The symphysis pubis is located with one finger and the puncture is made in one thrust in the midline about 2 cm above the symphysis, with the syringe held at a 20 to 30° angle from the perpendicular. A perceptible change in resistance is felt as the needle enters the bladder. Light suction is applied to aspirate the urine. The depth of penetration is variable but in infants averages between 2-3 cm. It may be necessary to rotate the needle if the bevel is against the bladder wall.
6. A sterile cork is placed on the end of the needle and the entire syringe after proper labelling is sent to the laboratory.

The entire procedure should be done rapidly before the infant is stimulated to void spontaneously. A specimen can be obtained (if the bladder is not empty) 90% of the time. *No local anes-*

TABLE II

RESULTS OF SUPRAPUBIC ASPIRATION BY SOME AUTHORS

Authors	*Total No. of Aspirations*	*Success Rate*	*Complications*
Nelson and Peters[7] (1965)	59 (all neonates)	90%	2/59 (3.38%) Hematuria
Saccharow and Pryles[9] (1969)	654 (infants and children)	92%	4/654 (0.61%) Gross hematuria
Abbot and Shannan[10] (1970)	3,000 (infants and children)	Not reported	1/3000, one needle which was insecurely set in the plastic hub stayed in the anterior abdominal wall and had to be pulled out separately
Zies and associates[4] (1968)	102 (all neonates)	Not reported	1/102 (0.98%) Hematuria
Edelmann and associates[2] (1973)	932 (all neonates)	Not reported	"No significant hematuria" (Percentage not reported)
Author* (1972-1974)	76 (74 preterms, 2 fullterms)	88.2%	3/76 (3.9%) Microscopic hematuria. 1 case of bowel perforation with no side effects.

* The author's study was conducted mostly in the Neonatal Intensive Care Unit, Milwaukee County General Hospital, Milwaukee, Wisconsin, and partly at Neonatal Intensive Care Unit, Raymond Blank Memorial Hospital for Children, Des Moines, Iowa. The author learned the technique at the beginning of his fellowship training in perinatology and himself did most of the suprapubic bladder aspirations undertaken by the study. 74 out of 76 patients were preterms with a mean weight of 1737 gm. Three out of 76 babies with suprapubic aspiration had microscopic or gross hematuria. In one preterm baby feces was aspirated in the syringe instead of urine, but the baby did not develop any complications. Her abdominal x-rays were normal and she did not require antibiotics.

thesia or after dressing is necessary. In case of failure the procedure can be redone 1 to 2 hours later prior to another voiding.

COMPLICATIONS

1. Transient microscopic and gross hematuria is seen in a small percentage of the cases (0.5 to 1%).

2. Three cases of bowel perforations have been reported. Two of these cases had abdominal distension. None of them suffered any apparent ill effects.

RECOMMENDATIONS

Physicians who have not done suprapubic bladder puncture are quite apprehensive about the procedure and do not utilize a simple, but valuable method of collecting a reliable urine sample. Critical time is wasted in a sick infant in getting a possibly contaminated bagged urine specimen. All of the reported studies indicate that suprapubic bladder puncture is safe, easy (especially in neonates), and the most useful method of obtaining urine for accurate diagnosis of urinary tract infections in neonates. The procedure is atraumatic and does not need any anesthesia. It should be done in all sick neonates before antibiotics are started, and when the findings of bagged urine specimen are equivocal. The complications associated with the procedure are negligible. It is urged that more physicians utilize the procedure.

ACKNOWLEDGMENT

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Echocardiography in Pulmonary Venous Obstruction

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Cardiac catheterization in severely ill infants presenting with pulmonary venous obstruction can be expedited if certain anatomic features can be defined before angiography. Echocardiography has proven to be a useful means of demonstrating distinguishing characteristics of three congenital heart lesions causing pulmonary venous obstruction in infancy: cor triatriatum, total anomalous pulmonary venous return and hypoplastic left heart syndrome. The echocardiographic findings aided in the construction of a plan for more selective angiography and rapid confirmation of the diagnosis.

THE INFANT with pulmonary venous obstruction is often critically ill and requires emergency diagnosis and treatment. Pulmonary venous obstruction is readily recognized radiographically by producing a characteristic reticular appearance.[1] Several conditions in infancy may produce this radiographic pattern including: cor triatriatum, total anomalous pulmonary venous return, and hypoplastic left ventricle. These conditions may produce very similar clinical profiles. This paper presents the characteristic echocardiographic findings in these 3 conditions which give direction at cardiac catheterization allowing for more rapid diagnosis and implementation of therapeutic measures.

Case Presentation I—Cor Triatriatum

A 5-week-old male infant was admitted to University Hospitals in Iowa City, Iowa following a "blue spell." One day prior to admission the child was noted to be dusky and tachypneic. Physical examination revealed a diaphoretic, tachypneic and tachycardic infant. The heart was hyperdynamic with a right ventricular heave. The second heart sound was narrowly split with accentuation of the pulmonic component. No murmurs were heard. There was an apical gallop. The liver was enlarged 4 cm below the right costal margin. The peripheral pulses were normal. The initial chest x-ray showed slight enlargement of the cardiac borders partially obscured by the pulmonary vascular markings which were interpreted as pulmonary venous congestion. The electrocardiogram showed right axis deviation and right ventricular hypertrophy.

An echocardiogram demonstrated the presence of two ventricular chambers, the right larger than the left. The ventricles were separated by an interventricular septum. The interventricular septal motion was normal. Two atrio-ventricular valves were identified. An echocardiographic sector scan (Figure 1A) from the left ventricle to the aorta demonstrated abnormal echoes encountered within the area of the left atrium. These echoes were from a structure obliquely traversing the left atrium to divide it into a true left atrium and an accessory left atrium or common pulmonary venous chamber. The septum remained visible behind the posterior wall of the aorta. The scanning technique is diagramed in Figure 1B.

At cardiac catheterization the pertinent findings were: elevation of the pressures in the right ventricle, pulmonary artery and pulmonary artery wedge position in association with normal pressures in the left atrium. Pulmonary angiograms demonstrated prolongation of the pulmonary venous return phase with distension of the pulmonary veins. A diaphragm dividing the dorsal accessory left atrium (common pulmonary ve-

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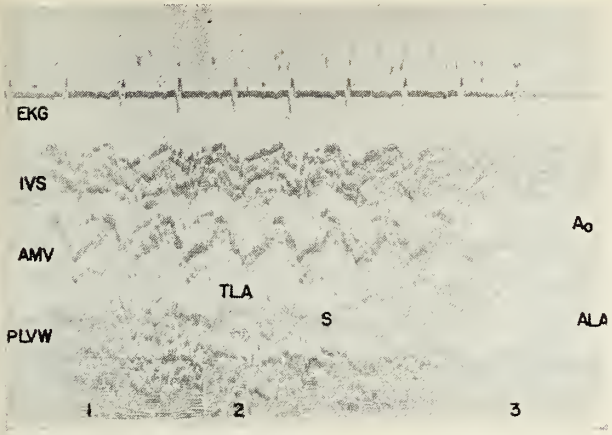

Figure 1A. Echocardiographic scan in patient with cor triatriatum. Numerals 1, 2, and 3 correspond to the transducer position in Figure 1B. In position 2 an abnormal septum obliquely separates the true left atrium from the accessory left atrium and persists behind the aorta in position 3.

nous chamber) from the true left atrium was seen.

At surgery the accessory left atrium was opened to reveal a fibromuscular diaphragm in which there was a 5 mm opening leading to the true left atrium. The diaphragm was excised to expose a normal appearing mitral valve below.

The child was significantly improved following surgery. A postoperative echocardiogram (Figure 1C) demonstrated the absence of the previously described abnormal echoes from the diaphragm within the left atrial cavity.

Case Presentation II—Total Anomalous Pulmonary Venous Return Below the Diaphragm

A 5-week-old male infant was referred to University Hospitals, Iowa City, Iowa for evaluation of a heart murmur. He was noted to have poor feeding and tachypnea since birth. The child had a cyanotic episode on the day prior to admission. Initial physical examination revealed a pale dusky tachypneic infant. There were intercostal retractions. The lungs were clear to auscultation. The precordium was hyperdynamic with accentuation of the pulmonic closure. There was a Grade ⅚ systolic murmur along the left sternal border and a prominent apical gallop. The liver was enlarged 3½ cm below the right costal margin. The peripheral pulses were diminished but equal by Doppler measurement. Electrocardiogram showed right axis deviation, right ventricular hypertrophy and right atrial enlargement. The chest x-ray showed a normal sized heart with marked pulmonary venous congestion.

An echocardiogram (Figure 2) demonstrated a

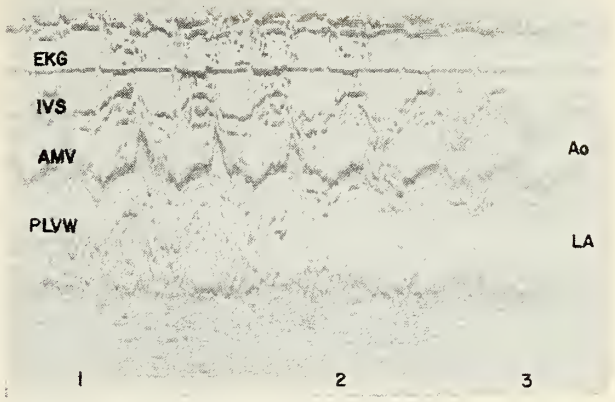

Figure 1C. Post-operative scan. The abnormal septal echoes are no longer present. Abbreviations: ALA = accessory left atrium; AMV = anterior mitral valve leaflet; Ao = aorta; EKG = electrocardiogram; IVS = interventricular septum; LA = left atrium; LVC = left ventricular cavity; PLVW = posterior left ventricular wall; RVC = right ventricular cavity; S = septum; TLA = true left atrium.

large anterior ventricle with a slightly smaller posterior ventricle. There were two atrio-ventricular valves with normal closure velocities. There was abnormal septal motion, Type A. No abnormal echoes were demonstrated within the left atrial cavity.

At cardiac catheterization the pressures in the right ventricle, pulmonary artery and pulmonary

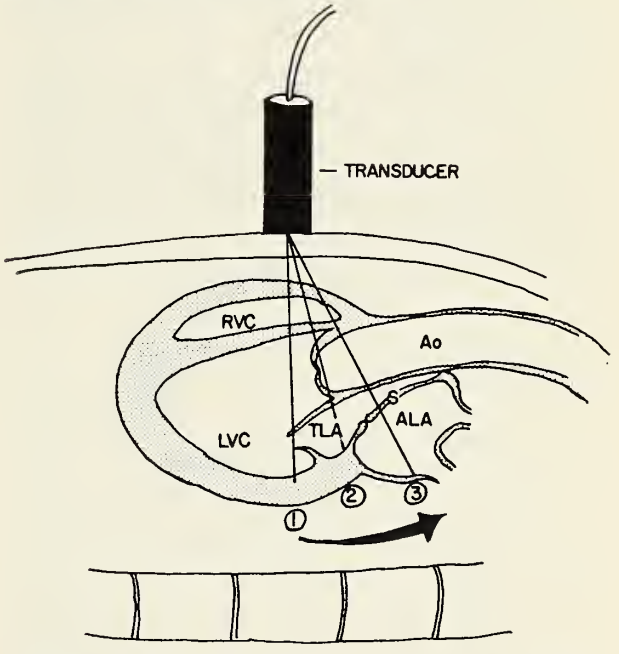

Figure 1B. Diagram corresponding to Figure 1A. Transducer position 1 is over the left ventricular cavity and anterior mitral valve leaflet. Position 2 is over the true left atrium and beginning portion of the septum separating the true left atrium from the accessory left atrium. The septum remains visible for a distance behind the aorta in position 3.

Figure 2. Echocardiogram of patient with total anomalous pulmonary venous return. There is an enlarged right ventricular cavity and abnormal interventricular septal motion. No abnormal septal echoes are recorded in the area of the left atrium. Abbreviations: AMV = anterior mitral valve; Ao = aorta; EKG = electrocardiogram; IVS = interventricular septum; LA = left atrium; PLVW = posterior left ventricular wall; TCV = tricuspid valve.

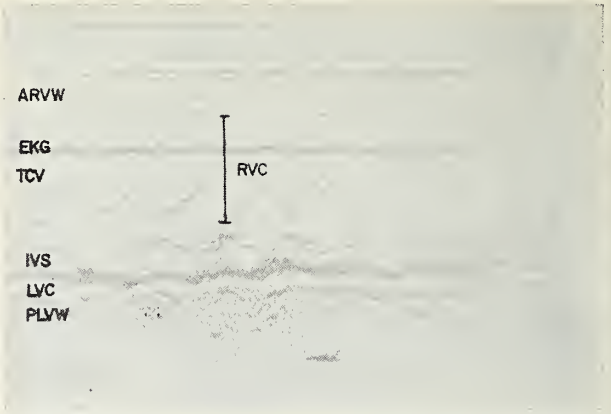

Figure 3. Echocardiogram of a patient with hypoplastic left heart syndrome. There is a very large right ventricular cavity containing the tricuspid valve separated from a diminuitive left ventricular cavity by the interventricular septum. Abbreviations: ARVW = anterior right ventricular wall; EKG = electrocardiogram; IVS = interventricular septum; LVC = left ventricular cavity; PLVW = posterior left ventricular wall; RVC = right ventricular cavity; TCV = tricuspid valve.

wedge position were elevated, while the left atrial pressure was normal. The pulmonary resistance exceeded the systemic resistance and there was reversal of flow through the ductus arteriosus. Pulmonary angiography demonstrated normal pulmonary arteries and extraordinary prolongation of the pulmonary venous phase with no visible return of contrast material into the chest or upper abdomen. There were no other intracardiac anomalies detected.

This critcally ill infant was taken to surgery where the diagnosis of total anomalous pulmonary venous return below the diaphragm was confirmed. The anomalous channel was ligated and the common pulmonary venous chamber anastomosed to the left atrium. The infant did well post-operatively and was discharged 10 days later.

Case Presentation III—Hypoplastic Left Heart Syndrome

A one-day-old male infant was transferred to University Hospitals, Iowa City, Iowa for evaluation of cyanosis and respiratory distress. At six hours of age the infant became deeply cyanotic and tachypneic. Initial physical examination revealed a critically ill tachypneic, cyanotic male infant. The peripheral pulses were diminished in all extremities. There was a Grade ⅔ systolic murmur at the left sternal border which radiated to the base. The second heart sound was single and accentuated. There was a prominent apical gallop. The liver was enlarged 4 cm below the right costal margin. The chest x-ray demonstrated evidence of severe pulmonary venous congestion with some mild enlargement of the heart. Electrocardiogram showed right axis deviation, right ventricular hypertrophy with hypoplastic leftward forces and ST segment changes suggestive of ischemia.

The echocardiogram (Figure 3) demonstrated a large anterior chamber containing an atrio-ventricular valve. An interventricular septum was identified. There was a very diminutive posterior chamber. An atrioventricular valve was not identified within the posterior chamber.

At cardiac catheterization there was systemic pressure in the right ventricle and main pulmonary artery. The foramen ovale could not be located. The catheter was placed in the femoral artery and advanced to the area of the left subclavian artery where it met with resistance. An angiogram from this site demonstrated a coarctation of the aorta, tubular hypoplasia of the arch and retrograde filling of a hypoplastic ascending aorta. Two coronary arteries were present.

The infant expired several hours later. The post-mortem examination revealed the left atrium received all the pulmonary veins; the foramen ovale was sealed. The mitral valve, left ventricle and aortic valve were all extremely small. There was tubular hypoplasia of the arch and a severe coarctation of the aorta just proximal to a large patent ductus arteriosus.

DISCUSSION

Congenital cardiac lesions causing pulmonary venous obstruction in infants frequently do

TABLE I

ECHOCARDIOGRAPHIC FINDINGS AS A GUIDE TO ANGIOGRAPHY

Echocardiography Findings	*Normal Newborn**	*Case I Cor Triatriatum*	*Case II Total Anomalous Pulmonary Venous Return*	*Case III Hypoplastic Left Heart*
Left ventricular end diastolic dimension	18.7 ± .3 mm	Normal (14 mm)	Slightly decreased (10 mm)	Very small (1-2 mm)
Right ventricular end diastolic dimension	11.4 ± .4 mm	Increased (17 mm)	Increased (22 mm)	Increased (27 mm)
Left atrium	7.0 ± .1 mm	Membranous structure traversing left atrial chamber	No abnormal echoes present within left atrial chamber	Increased (17 mm)
Mitral valve motion	Normal	Normal	Normal	Absent
Interventricular septal motion	Normal	Normal	Abnormal volume overload pattern	
MOST PRODUCTIVE ANGIOGRAM		Pulmonary angiogram with pulmonary venous return	Pulmonary angiogram with pulmonary venous return	Aortogram

* Data taken from Hagan, A., Deely, W., Sahn, D., et al.[2]

not have clinical, radiographic or electrocardiographic findings that allow for accurate anatomic diagnosis. At cardiac catheterization the right heart study in most patients shows similar findings of increased right ventricular and pulmonary artery pressure and an elevated pulmonary wedge pressure. Left sided catheterization studies and angiography may allow the differentation of these conditions, but rapid diagnosis is often difficult in the critically ill infant. Cardiac catheterization in the critically ill infant carries considerable risk. Therefore, the manuevers and angiography should be carefully selected and minimized to those which will yield diagnostic information.

Echocardiographic data can provide useful information *prior* to cardiac catheterization, guiding the cardiologist to select appropriate angiograms to expedite diagnosis. The normal newborn echocardiographic measurements have been documented.[2] The echocardiogram should include an attempt to identify all four cardiac valves. Both ventricles, if present, should be displayed as well as the left atrium and aorta. After identification of the heart structures and measurements of the cardiac dimensions, an echocardiographic profile can be constructed. Certain abnormal echocardiographic findings are useful in the differential diagnosis of lesions causing pulmonary venous obstruction in infants. These findings are summarized in Table I. These guidelines can be used to construct a diagnostic plan for the anatomic diagnosis of infants with pulmonary venous obstruction at the time of catheterization.

Cor triatriatum is suggested by the findings of a large right ventricular dimension, normal interventricular septal motion, normal left ventricular size and abnormal echo obliquely traversing the left atrial cavity. Within this framework the cardiologist may select the pulmonary angiography as the primary contrast study. The lateral projection best demonstrated the obstructing diaphragm in our patient.

Total anomalous pulmonary venous return is a lesion which may have similar hemodynamics as cor triatriatum. This lesion becomes hemodynamically significant by one or a combination of mechanisms: inadequate output to systemic circulation; obstruction to pulmonary venous return; or volume overload of the right ventricle.[3] It is this last mechanism by which echocardiographic recording of abnormal septal motion is seen in lesions causing right ventricular volume overload.[4, 5] Therefore, echocardiographic findings of a large right ventricular dimension with abnormal septal motion associated with normal or slightly diminished left ventricular and left atrial dimension is highly suggestive of this lesion. No abnormal echo is seen within the left atrium as described in the patient with cor triatriatum.

Angiography was not particularly helpful in our case where the pulmonary venous phase was so prolonged that the contrast was insufficient to define the pulmonary veins or left atrial anatomy.

The clinical history, catheterization data and echocardiogram gave sufficient information to make a reasonable diagnosis of total anomalous pulmonary venous return below the diaphragm and the patient was sent to surgery.

The echocardiographic findings of hypoplastic left heart syndrome are well described and are diagnostic.[6] These include an increased right ventricular dimension with normal interventricular septal motion. Only one atrioventricular valve can be identified and this lies within the large anterior ventricular chamber. A diminuitive posterior chamber is identified but is lacking a normal atrio-ventricular valve. The aorta is hypoplastic. The left atrium in our patient was large and may be due to premature closure of the foramen ovale. With these echocardiographic findings an aortogram is the study of choice to confirm the diagnosis. In several patients having the clinical and echocardiographic features of hypoplastic left heart syndrome, an umbilical arterial line has been inserted and advanced to the area of the aortic arch and angiography performed to confirm the diagnosis. This eliminates the need to invade the femoral artery.

These 3 infants with obstructed pulmonary venous flow demonstrate the utilization of echocardiography prior to cardiac catheterization and angiography. Pre-cardiac catheterization echocardiograms give direction to the appropriate site for contrast injection at the time of angiography.

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n in purpose of drug information
f the patient is to get his coopera-
t n in following a drug regimen.

**:paration and distribution of
ient drug information**

We would hope to amass infor-
ation from physicians, medical
cieties, the pharmaceutical indus-
t and centers of medical learning.
e ultimate responsibility for uni-
f m labeling must, however, rest
h the Food and Drug Administra-
n. There is nothing wrong with
t s agency saying, "this informa-
n is generally agreed upon and
erefore it should be used," as long
our process for getting the infor-
ation is sound.

Distribution of the information
a problem. In great measure it
uld depend on the medication in
estion. For example, in the case
an injectable long-acting proges-
rone, we would think it mandatory
issue two separate leaflets—a
ort one for the patient to read be-
e getting the first shot and a long
e to take home in order to make a
cision about continuing therapy.
this case, the information might
put directly on the package and
t removable at all. But for a medi-
tion like an antihistamine this
formation might be issued sepa-
tely, thus giving the physician the
tion of distribution. This could
eserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

---

ly the doctor can remove that fear
20 or 30 minutes of conversation.

I'm not suggesting that we
thhold any information from the
tient because, first of all, it would
: totally dishonest and secondly, it
uld defeat the very purpose of the
sert. I do think that a patient on the
rth control pill should know about
e incidence of phlebothrombosis.

If you're going to tell a patient
e incidence of serious adverse re-
tions, then you have to tell him
at a concerned medical decision
as made to use a particular medi-
ation in his situation after careful
nsideration of the incidence of
mplications or side effects.

**motionally unstable patients pose
special problem**

There are patients who, be-
ause of severe emotional problems,
uld not handle the information
ntained in a patient package in-
ert. Yet if we are going to have a
ackage insert at all, we just can't
ave two inserts. I think we might
imply have to tell the families of
ese patients to remove the insert
om the package.

**egal implications of the patient
ackage insert**

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

Wandering Spleen in the Child: A Case Study

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JOHN J. POLICH, M.D., and
JON S. VAN CLEAVE, D.O.
Des Moines

This rare abnormality presents a diagnostic challenge. Its pre-operative determination is difficult. Once determined, the authors regard splenectomy as the correct treatment.

Wandering spleen is very rare. It is most unusual in children. It is rarely diagnosed preoperatively. The correct treatment is splenectomy in children as well as in adults.

CASE REPORT

A 4-year-old Caucasian girl was admitted to Mercy Hospital, Des Moines, Iowa, for evaluation of a mass discovered in a routine examination by one of the authors. The mother was unaware of the presence of the mass. There were neither urinary tract nor gastrointestinal symptoms. The child was healthy appearing with positive findings confined to the left flank area. A firm, moveable, non-tender, elliptical-shaped mass was observed. It did not move with respirations. No notch was palpable. There were no other abnormal physical findings. The patient's temperature was normal. All laboratory studies, including a complete blood count, urinalysis, and SMA-12, were within normal limits. A chest x-ray, upper G.I. series, barium enema, and IVP were within normal limits. A liver and spleen scan was reported as showing a normal distribution of the isotope throughout a normal size liver and spleen. The elliptical mass in the left flank was noted on the scan, but appeared to be other than the spleen or liver.

An exploratory laparotomy was performed and the mass was found to be a normal appearing spleen on an extremely long pedicle with no peritoneal or ligamentous attachments. The spleen was extremely mobile, assuming almost any position in the abdominal cavity. The left subdiaphragmatic space was occupied by the left lobe of the liver and both liver and spleen appeared to be normal. Because of the child's age, a judgment was made not to remove the spleen for fear of increased susceptibility to infection, known to occur in children following splenectomy. The patient's post-operative course was uneventful. She was discharged on the fifth post-operative day.

Six months later, the patient was readmitted to Mercy Hospital when an elective splenectomy was performed. The spleen and its pedicle, intact, are shown in Figure 1. This patient's post-operative course was again uneventful. She was discharged on the seventh post-operative day.

DISCUSSION

Ever since Abell's landmark study in 1933 of 97 cases of the rare surgical condition known as wandering spleen, this diagnostic challenge has remained one of the unusual anatomical abnormalities. This is especially true in the pediatric age group, particularly with the need for surgical extirpation of the spleen. Of the 97 cases described in Abell's review of world literature, only one was under 10 years of age.[1] More recently, however, a report from the Mayo Clinic described a 4-year-old male with torsion of the spleen. The report indicated only 2 cases of wandering spleen were found among 1,003 splenectomies performed at Mayo between 1904 and 1945.

Moreover, no cases of wandering spleen were

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recorded among 1,437 cases of splenic pathology studied at the Combined Splenic Clinic of the Columbia Medical Center during the previously noted time period.[6]

As rare as the abnormality is in North America and Europe, the condition is somewhat more common in Africa, especially in the pediatric age group. A recent report states that wandering spleen is the second most common cause for spleen surgery at the Mulago Hospital in Uganda. The report reviewed 11 cases of wandering spleen between 1968 and 1971 at 2 African hospitals, with only 2 of these patients over the age of 10; the youngest male being 6 years old, the youngest female being 7 years old.[5]

In 1952, Maingot found less than 150 cases reported in the literature.[3, 9] In 1974, Carswell stated that about 350 cases had been described prior to 1968.[5] Hence, it is conservative to estimate that, to date, probably less than 400 cases of wandering spleen have been described in world literature. Moreover, it is likely that the case study presented here is the first reported of a wandering spleen in a female under 10 years of age on this continent. Furthermore, it is likely that this patient is the youngest female with a wandering spleen to have been reported so far in world literature.

"Wandering," "floating," "aberrant," "dystrophic," or "displaced" are terms applied to the unique condition in which the spleen has developed with an abnormally long pedicle which permits it to assume an abdominal location variable to its normal bed in the left hypochondrium.[4, 6] Depending on the spleen's assumed position and the degree of torsion of its pedicle, the condition may exist asymptomatically or present as an acute abdominal emergency.

Abell categorized the initial attack as acute, subacute, or chronic. His symptomology included intestinal colic, digestive disturbances, pelvic discomfort, metrorrhagia, and melena probably due to circulatory changes. The acute attack often presents with pain, nausea, vomiting, tachycardia, leukocytosis, and elevation of temperature while conveying the presence of an abdominal catastrophe. In the subacute and chronic varieties, the symptoms relate to the location of the organ. It may have adhered to the intestine via the omentum enabling the patient to survive the acute attack, or the pedicle may stop short of strangulation and present only as an abdominal mass in a chronic situation.[1, 12]

Wandering spleen may be either congenital or acquired. In the former variety, the malposition of the spleen may be due to the absence of the supporting phrenicocolic ligament or due to excessive length of the pedicle.[9, 10] Moreover, in further explanation of the congenital factor, it has been noted in recent case studies that a significant incidence of an abnormally mobile cecum and ascending colon has also been present.[5] In the acquired type, the causes may be due to the stretching and elongation of the anchoring peritoneal folds or suspensory ligaments, or due to increased weight of the spleen, or relaxation of the abdominal wall and intra-abdominal ligaments supporting the viscera. Hence, when the spleen becomes excessively mobile, pain is caused by the traction on, or torsion of, the vascular pedicle.[9, 10]

Figure 1. View of wandering spleen during surgery.

The wandering spleen may be found in any part of the abdomen, or even outside the abdomen. It is reported to occur much more frequently in adult women than in men while having a considerably higher incidence in the multiparae. By 1943, only 3 cases in children had been reported.[7] And by 1974 an estimate of less than 15 cases of children with wandering spleen had been made in the world literature. Hence, due to the variety of locations the spleen may assume, and due to the rarity and distribution of the cases reported, an accurate pre-operative diagnosis is a difficult task.[1, 8, 10–12] Abell reported only 19 correctly diagnosed cases out of the 97 studied.[1, 8] Available today, however, are such sophisticated diagnostic procedures as abdominal angiography, scintillation scanning, and fiberoptic gastroscopy. These aid obviously in cases which may, for in-

stance, mimick fundal lesions of the stomach.[8] In addition, Carswell notes the use of Cr intravenously, a radioactive medium selectively taken up by the spleen.[5] He contends that while the test provides an "elegant confirmation of a suspected wandering spleen," it has no value once torsion has occurred.[5] Thus, despite modern technology, the diagnostic challenge remains.

Grindrey and Piquard in 1966 attempted to help relieve this clinical frustration by describing a diagnostic triad:

"1. Palpation of a hard ovoid abdominal mass with a crenate border.

"2. Special mobility of this mass, i.e., painless movements toward the left hypochondrium, but painful and limited movement in every other direction.

"3. Resonance to percussion in the left upper abdomen."[5]

This triad is not widely known. Moreover, as evidenced by previous discussion of the wide variety of positions the spleen may wander to, this triad would not appear to be diagnostic in the many exotic cases possible.

TREATMENT

Splenectomy is the recommended treatment whether complications exist or not.[6, 9] Conservative measures such as attempting to untwist the pedicle are contraindicated by all recent sources save one.[7] In this exception, Carswell reports a "reefing procedure" performed in Uganda where the lengthened splenic pedicle was shortened and thickened by inserting four separate running sutures of non-absorbable material along its length with each suture pulled tight and tied. The patient progressed with an uneventful postoperative recovery. Note that this procedure was performed in Africa where many surgeons are fervently opposed to removing normal spleens because of their known substantial resistance to malaria which is endemic in many parts of Africa.[5] Splenoplexy, originally performed by Tuffier in 1882, is dismissed nowadays and is mentioned only for historical interest.[7] However, Carswell argues in favor of the reefing procedure "provided that the wandering spleen has not undergone torsion and that there are no significant adhesions between the spleen and other viscera."[5] In any event, the results of the splenectomy are satisfactory although the mortality rate in pregnant women is considerable.[7]

Much has been written about the results of splenectomy in the child in which postoperative susceptibility to infection is an important consideration. Barnett notes the spleen as a source of protection against infection is "relatively great in early infancy, becoming much less in childhood, and possibly tapering off into insignificance in the mature subject."

Recent studies have further clarified the issue with three points emphasized: (1) the increased susceptibility to infection varies with specific types of infection, notably overwhelming and often fatal sepsis and meningitis, mostly due to pneumococcus. (2) As there is no overall decrease in general immunity, gammaglobulin, or impaired antibody formation, the danger of sepsis is due to loss of filtering function of the spleen. (3) The relative degree of susceptibility is related to any underlying predisposing disease entity. That is, the incidence of sepsis is higher in patients compromised by an underlying disease process which has caused a general decrease in resistance than in those patients whose basic disease was not accompanied by a lowered resistance. However, it is noted that if splenectomy is performed under one year of age even in a "non-predisposed" group, the incidence of sepsis may rise to 15%. The majority of cases of sepsis or meningitis are due to pneumococcus with over 20% of the cases occuring within two years after removal of the spleen.[2] Carswell states that pneumococcal sepsis, if it occurs, usually affects children under 4 years of age.[5] Smith advised penicillin prophylaxis for 2 years after splenectomy.[2] On the other hand, DeBartolo, et al., state they use antibiotics only in cases in which the spleen is diseased. Moreover, they contend that only 1% of a large number of children who have had splenectomies because of trauma died later of infection.[6]

SUMMARY

An interesting case of wandering spleen has been presented with a review of the world literature. Because it is a rare entity, and uncommonly diagnosed pre-operatively, a surgeon may find himself faced with a difficult decision whether to remove a normal appearing wandering spleen. It has been established that the correct treatment is splenectomy to avoid such complications as torsion, infarction and increased susceptibility to rupture because of loss of the normal protection of the thoracic cage.

This diagnosis should be kept in mind in the case of an abdominal mass. It should be noted

that splenectomy in any age group is associated with a higher risk of sepsis, especially pneumococcal. This is especially true in an infant less than 1 to 2 years of age. After 2 years of age, the advantages of splenectomy far outweigh any risk of postsplenectomy infection since susceptibility to sepsis gradually reaches the point of insignificance with increasing age.

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The references noted in this article are available either from the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

STATE DEPARTMENT OF HEALTH

(Continued from page 8)

the Parasitology Laboratory, Parasitic Diseases Branch.

There were some variations in the prevalance rates between refugee centers for all of the pathogens found (Table 1). The prevalence rates for the protozoans were 2.0% for *Entamoeba histolytica,* and 8.2% for *Giardia lamblia.* The prevalence rates for the helminths (Ascaris, Trichuris, Hookworm, and Strongyloides) were 30.5%, 9.0%, 4.1%, and 1.2% respectively. The prevalence rates showed no statistically significant variation with age, sex, gastrointestinal symptoms, or place of origin in Vietnam.

(Reported by Parasitic Diseases Branch, Parasitic Diseases and Veterinary Public Health Division, Bureau of Epidemiology, CDC.)

EDITORIAL NOTE

Although data on prevalence rates for intestinal protozoan parasites in the United States are somewhat limited in scope and not recent, the rates of 5.0% for *E. histolytica* and 1.5-9.5% for *G. lamblia* have been reported *(1-5)*. Therefore, the rates of 2.0% for *E. histolytica* and 8.2% for *G. lamblia* among the Vietnamese refugees do not appear significantly different from those estimated for the indigenous United States population. Consequently, the refugees do not present an increased threat of spreading these diseases. In addition, there have been no reported cases of giardiasis or amebiasis attributed to Vietnamese refugees.

Transmission of Ascaris, Trichuris, Hookworm, and Strongyloides requires a minimum of 1-2 weeks incubation in the soil, and therefore can be interrupted by the use of toilets. Consequently, regardless of their prevalence, helminth infections in the refugees do not pose a public health threat to the U. S. population.

Physicians providing medical care for the refugees should consider examination for helminths and protozoans, and treatment if they are found, since these organisms do pose a personal health problem. However, this survey supports previous recommendations that mass chemotherapy of the Vietnamese refugees is an unwarranted public health measure.

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Editorials

M. E. ALBERTS, M.D., Scientific Editor

LOOKING TO THE FUTURE

As I gaze out upon the beautiful blue waters of the Caribbean, enjoying the warm sunshine and the roaring sound of the surf, it is difficult to think of the future. The present is at a standstill. Nothing else seems to matter. Yet, here in Cancun, in spite of the tranquil life, the future is in the minds of these people of the Yucatan peninsula. The ancient Mayas were uncanny in their predictions of the future. Their knowledge of mathematics and astronomy and agriculture was far advanced. Today their projections for the future are again great. From a wasteland of sand and jungle a great resort area is developing with consideration of monetary increases in the future. This is an economic venture to capture millions of pesos from tourists.

We now start a New Year after a hectic and eventful 1975. Our professional life has been concerned with medical practice liabilities, rising costs of office and home expenses, and the stark realization that physicians in some areas have resorted to strikes. Society blames the physicians for all the ills of medical care; the physicians resent the dictates of society toward ways of reforming the state of health care delivery. The patient-physician relationship seems to be the great area of concern. What, then, shall the future bring for the solution of this dilemma?

The man of medicine has been a creature of mystique to the people he must serve, whether he be the medical shaman of the jungle tribe or the pompous professor in a large medical center. Hope and faith were dispensed along with the medicines. The physician was equated with priests and lords, yet he was a simple human being with a few special skills and much compassion. The people he served were his first interest, day and night, often at personal sacrifice.

Recently, I read an interesting essay written by Eleanor Hoover, human behavior writer for the LOS ANGELES TIMES. Her article entitled, "Self Interest Erases Image of Folk Hero" appeared in the November 2, 1975, issue of the TIMES. The author's theme is that police, firemen and doctors of the past lived in an aura of a romanticized folk-hero image; noble, stalwart, and selfless. Now, they have changed the direction of their lives to increased self-interest; increased self-consideration of the cost of malpractice insurance, need for negotiation with the bungling bureaucracy of welfare medicine, and concern for improvements in public hospital patient care and facilities. In other words, the impact of economics has struck the doctors, the policemen and the firemen as it has the factory worker, the school teacher, and the common laborer. Serious psychological and sociological factors have entered the lives of all of us, requiring a sense of self interest and the use of collective power to attain certain objectives. In the medical world the salaried physicians have used collective powers to the most advantage utilizing strikes against hospitals as a function of union organization. Through our medical associations we have been able to a greater or lesser degree attain some changes in legislation. Yet, some segments of our population cry that actions by physicians in such matters are unethical.

A poll taken by the LOS ANGELES TIMES reveals 21 per cent of those questioned believed that physicians do not have the right to strike because

we have taken the Hippocratic oath to serve people. However, 24 per cent, when questioned in another way, said physicians do have a right to strike because we are independent businessmen and can do with business as we please.

Medical care of the past was a private and very confidential matter between the patient and his doctor. That is not the situation today. Our confidential relationship is breached by our requirements to relate to third parties (governmental, insurance carriers, hospital peer committees, and many others). I seriously doubt the average patient realizes how many others know the details of his health status. Yet, I wonder how many patients really care about confidentiality of their personal life. We relate to others confidential data about our economic status if we desire to obtain a monetary loan. People of the past bartered with what they had for what they desired. Now a line of credit is our way of life and many computers have our number. Our health rating is programmed as well, to be made available to nearly any and all, regardless of that admonition of confidentiality. Personal affairs no longer seem sacred.

There is resentment to this invasion of privacy, and we must strive more and more in the future to protect the patient-physician relationship. Advances cannot be made by being negative. Battles are not won by passive inactivity hoping the adversary will go away. One cannot be against everything as a protest, as some organizations in our profession seem to be inclined. It is unfortunate that some, in an apparent automatic way, are against every proposal; yet, never demonstrate any constructive programs in a positive manner.

Now, back to this sun and sand and surf atmosphere. The warm sunshine and refreshing breezes are good for the heart and soul. The footprints in the sand are quickly washed away by the surf, each wave casting its own peculiar pattern on the beach, only to be changed by the next wave. The future appears to be very bright here in Cancun. Our future in medicine and society as a whole can be equally bright, but not by making waves that erase our footsteps. We must be more positive; more constructive. We must cease worshipping our past images. We must strive to work with society to permit mutual accomplishments for the good of all. Medical service is a necessity; but ours is not a profession of pure servitude. The economy and the bureaucracy of the times has changed that aspect of our calling. The problem lies in the how and the where and the way. The future is exciting and with society, not against society, we can determine our ultimate destiny.—M.E.A.

THE SEVEN-YEAR ITCH

The itch to which the title alludes is not the type made popular by a movie several years ago. Historically the seven-year itch dates back to the ancients, and finally in the 17th century the mite responsible for scabies was discovered. I had not seen a case of scabies for over 20 years until recent months. Now this infestation of the ancients seems to be upon us in epidemic proportions. The diagnosis depends upon our awareness of its possibility when the typical lesions are obvious. It is not clear why this scourge of the past is making such a comeback, not only in the United States but also throughout Europe. Some suggest a relationship with the recent conflicts in Korea and Viet Nam; others have no answer. The incidence in the U. S. was first noted in San Francisco and later in southern California; now we are seeing a relatively large number of cases in Iowa, especially during the past 6 months.

The scabies mite *Sarcoptes scabiei* var. *hominis* is transmitted by close personal contact, and indirect spread by clothing and bedding is relatively unimportant. The lesions may be papules, vesicles, wheals, crusts, with burrows between lesions. Secondary infection of the various lesions is common. Itching may be so intense as to cause excoriations as well.

The seven-year itch is upon us, doctor! Review your knowledge about scabies. The treatment is simple in most instances. The most common and effective remedy is the use of a one per cent lindane preparation available commercially as Kwell®.—M.E.A.

The Question Box

W. C. KEETTEL, M.D.

HOME DELIVERIES?

What are the merits and dangers of delivering babies in the home as opposed to the hospital? This question has been discussed recently in the lay press. Following are brief views on the question from W. C. Keettel, M.D., professor and head, Department of Obstetrics and Gynecology, University of Iowa College of Medicine.

What is your feeling regarding the delivery of a baby in the home rather than in the hospital?

The hospital delivery offers the mother and her baby the best opportunity for optimal care. Fortunately, the majority of labors and deliveries are uncomplicated. However, there are a number of complications which cannot always be predicted. Examples are prolapse of the cord, postpartum hemorrhage and anoxic states of the newborn. If these complications are not promptly and properly treated they may result in a maternal or perinatal death. It is interesting in England where a number of deliveries are performed by trained midwives they are conducted in the hospital where there is an optimal environment for care.

Is it correct to assume that virtually all obstetrical deliveries in Iowa are in hospitals?

Since 1960, 99-plus percent of all deliveries in Iowa have been in hospitals. The only ones not delivered in the hospital are the occasional patients who develop very rapid labor and deliver on the way to the hospital.

Was the custom of home delivery prevalent in Iowa during your early professional years?

When I finished my residency in obstetrics and gynecology in 1940 the number of home deliveries were rapidly decreasing and by the end of World War II, they were uncommon. Since that time almost all deliveries have been in hospitals. This change occurred because institutional deliveries offered a better opportunity to observe the patient and the fetus during labor and delivery and to treat any complication immediately. During this transition from home to hospital deliveries there was a marked reduction in maternal and perinatal deaths. It should be recognized, however, during this same period (1940-1950) there were also many medical advances, such as the introduction of antibiotics and the availability of whole blood. These also influenced the quality of care.

Would you have information on Iowa's maternal and perinatal mortality rates as compared with other states or nations? It it good?

In the last five years there were 5-7 maternal deaths per 40,000 deliveries, which is lower than most states. Our perinatal mortality has decreased from 30.1 per 1,000 in 1966 to 21.3 in 1974. This is among the lowest of any state.

CONTINUING EDUCATION COURSES & CONFERENCES

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

Jan. 7	Ophthalmology Clinical Conference	Feb. 4	Ophthalmology Clinical Conference
Jan. 26-30	Cardiology Today	Feb. 17-20	Refresher Course for Family Physician

Medical Assistants

by TENORA MEYER, CMA

THE YEAR AHEAD

An American tradition is the "New Year's Resolution." It is important for all of us to examine ourselves and consider plans for making our lives run more smoothly. As medical assistants, we must be concerned with how our offices are run. Today's increase in number of patients is a concern which creates a need to streamline procedures. Planning activities can be difficult for some people. Some have the ability to grasp the priority work functions more easily than others. Efficient planning is affected or controlled by the attitude, knowledge and skill of the individual. A suggestion is to keep a record of what you are really doing each day to try to determine if you are giving the right time to important things. An experiment with work organizers may produce the desired result. A folder for "immediate attention," one for tomorrow, and one for next week may help to sort out the important and emergency tasks.

Some time-savers that cost almost nothing and help keep things organized are:

1. Use the fast answer system when applicable. Answer simple requests for information on bottom or back of request letter—making a photocopy of the letter and reply for the office file.
2. Plan and use form letters when applicable.
3. Keep a list of telephone numbers and addresses you frequently use posted where it can be easily seen.
4. Use a notebook and jot down items you wish to discuss with your doctor, or other employees, or patients and cross them off as they are taken care of. DO NOT TRUST YOUR MEMORY.
5. Use sorting folders for filing reports and charts.

YOUR APPOINTMENT SCHEDULE

The appointment schedule is essential to a smooth-running office. A reference chart, incorporating the average time necessary for various examinations and procedures, kept with the appointment book, helps assure that the proper amount of patient time is reserved. A letter code may be devised for the various procedures and used by each patient's name in the appointment book. This helps eliminate errors in timing and gives the reason for a patient's visit. It must be emphasized that time should be left for handling emergencies, answering phone calls, etc. Patients frequently call to check the date or time of their appointments. To eliminate a search through the appointment book, a note can be placed in patient's record listing the next appointment.

TELEPHONE

The medical assistant's telephone response is of particular importance, since this method of communication is usually the patient's first contact with the physician. Since considerable time is spent on the telephone, thought should be given

(Please turn to page 28)

CERTIFICATION

Medical assistants desiring to submit an application for certification must submit the application postmarked no later than February 1 for the spring examination held June 4, 1976. A list of tentative test centers is available upon request. Applications postmarked February 2-February 15 will be considered if accompanied by a "late fee" of $10. The basic certification exam plus specialty exams will be offered in the spring session. Fees must be submitted with the application.

MEDICAL ASSISTANTS

(Continued from page 27)

to methods of handling calls most effectively. Outline acceptable ways to handle difficult calls: the caller who won't identify himself initially; the patient complaining about a fee, which he feels is too high; the patient who doesn't understand his insurance coverage; the patient who requests a different diagnosis on his insurance form because he feels his company won't pay for the diagnosis the physician has entered on the form; and emergency calls. During telephone conversations, it is important to refer to your physician by name, rather than as "the doctor." Be discreet in using a caller's name, if there is someone in the waiting room. It is best not to use names but rather let tone of voice show recognition.

Morbidity Report for November, 1975

Disease	Nov. 1975	1975 to Date	1974 to Date	Most November Cases Reported From These Counties
Amebiasis	1	20	31	Linn
Ascariasis	3	18	10	Kossuth, Mitchell
Brucellosis	10	23	17	Dubuque, Polk, Woodbury
Chickenpox	1098	8149	7666	Scattered
Conjunctivitis	185	1274	935	Scattered
Encephalitis				
due to ECHO 4	1	7	5	
due to ECHO 6	1	1	0	Polk
a/w Coxsackie A9	1	1	0	Johnson
due to SLE	4	11	0	Benton, Decatur, Monona, Polk
due to CEV	3	9	2	Black Hawk, Johnson, Polk
due to WEE	1	5	0	Polk
a/w Herpes simplex	1	5	2	Marshall
viral, agent unknown	1	6	17	
Erythema infectiosum	39	198	568	Crawford, Ida
Gastrointestinal viral infect.	3608	21465	14686	Scattered
Giardiasis	1	25	42	Louisa
Hand, Foot and Mouth Disease	1	12	7	Benton
Hepatitis				
A (infectious)	17	167	28	Iowa
B (serum)	4	86	84	Linn, Polk
type unspecified	2	29	47	Lucas
Impetigo	214	861	600	Scattered
Infectious Mononucleosis	190	1194	1048	Polk, Winneshiek
Influenza-like illness	5443	46487	100183	Scattered
Meningitis, meningococcal	1	6	9	Woodbury
Aseptic, agent unknown	1	10	56	Muscatine
due to ECHO 4	2	3	16	Dubuque, Linn
due to *H. poroinfluenzoe*	1	1	0	Dubuque
due to *H. influenzoe*	1	18	5	Johnson
bacterial, agent unknown	1	10	6	Pottawattamie
a/w CDC Group II-K, type 1	1	1	0	Pottawattamie
Meningoencephalitis	1	4	5	
Mumps	233	1387	1888	Polk
Myocarditis, a/w Coxsackie B4	1	1	0	Clinton
Pediculosis	88	405	677	Scattered
Pinworms	6	41	62	Polk
Pneumonia	116	1052	923	Scattered
Rabies in Animals	8	98	118	Scattered
Rheumatic fever	1	14	54	Dubuque
Ringworm				
body	53	293	232	Scattered
scalp	1	10	15	Jackson
Rubeola	58	679	134	Dubuque
Salmonellosis	12	183	191	Scattered
Scabies	193	645	150	Scattered
Shigellosis	4	60	292	Scattered
Streptococcal infections	1206	9072	9357	Scattered
Tuberculosis				
total ill	17	121	115	Scattered
bacteriologically positive	14	81	15	
Trichuriasis	1	10	6	Linn
Venereal Diseases				
Gonorrhea	733	6614	5758	Scattered
Syphilis	30	278	348	Scattered

Laborotory Virus Diognosis Without Specified Clinical Syndrome

Adenovirus 2, Eaton's agent infection 10, Echo 4 infection 3, ECHO 6 infection 1, Herpes simplex 11

About IOWA Physicians

Dr. H. H. Gessford, George physician for 29 years, retired in October. . . . **Dr. Gerald Solomons,** director of Child Development at U. of I., spoke on "battered child syndrome" at fall conference of Iowa Juvenile Probation Officers Association. . . . **Dr. Thomas R. Thurman** has joined the newly formed Radiology Associates group in Ottumwa. Dr. Thurman received the M.D. degree at U. of I. College of Medicine and interned at Kansas City General Hospital in Kansas City, Missouri. . . . **Drs. H. O. Stoutland,** Ackley, and **T. C. Graham,** Iowa Falls, left on November 1 for a tour of medical duty in Yucatan and Campeche, Mexico.

Red Oak's Family Care Center moved to its new quarters, adjacent to Murphy Memorial Hospital, December 15. Offices of **Drs. Harold Bastron, Jack Fickel** and **William G. Artherholt, D.O.** are located on the first floor; lower portion is occupied by **Drs. James Sheehan** and **Glenn Skallerup.** Drs. Bastron and Fickel closed their solo practices last year and formed the Family Care Center. Dr. Artherhold, D.O. joined the group in July, 1975, after completing his family practice residency at Wesley Medical Center in Wichita, Kansas. He received the D.O. degree from Des Moines College of Osteopathic Medicine and Surgery in 1972. **Dr. Charles E. Driscoll** and **Dr. Francis L. Pisney** will join the group next summer, following completion of service with the Air Force and National Health Service Corps, respectively. Both are 1971 graduates of U. of I. College of Medicine and completed their residency training in family practice at Ball Memorial Hospital in Muncie, Indiana. Red Oak is the site of the Model Regional Primary Care Program developed in conjunction with the U. of I. College of Medicine. . . . **Drs. Melvin L. Marcus** and **Carl W. White,** assistant professors of internal medicine at U. of I. College of Medicine, have been granted Fellowship in the American College of Cardiology.

Dr. George L. Baker, professor of pediatrics and associate dean of student affairs and curriculum at U. of I. College of Medicine, was guest speaker at annual holiday dinner of Clinton County Medical Society. Dr. Baker spoke on "Medical Education in Iowa in 1975." . . . **Dr. Donald V. Hirst,** Council Bluffs, has authored his first hardback book, entitled "Origins of Human Nature and Human Behavior." The book represents 15 years research and discusses the emotions of women, their origins and dangers. Dr. Hirst has authored and co-authored more than a dozen formal clinical and medical research papers in gynecology, endocrinology, cytology and medical practice. . . . **Dr. Ronald Flory,** who has been stationed at Clark Air Force base in the Philippines for nearly two years, will return to Grundy Center and resume his medical practice in 1976. . . . **Dr. C. E. Hartford,** Iowa City, chairman-elect of the Governor's EMS advisory council, was keynote speaker at second annual regional conference on Emergency Medical Services (EMS) conducted by the Hoover Health Council and Medical Emergency Response Group. Iowa City physicians, **Drs. Thomas Rosenberger,** and **A. R. Sherburne** also participated in the Conference.

Dr. F. W. Bennett, Marion, has been reappointed by Governor Robert D. Ray to Governor's Task Force on Alcoholism and Drug Abuse. Dr. Bennett is member of the IMS Committee on Alcoholism and chairman of IMS Committee on Drug Abuse and the Linn County Ad Hoc Committee on Alcoholism. . . . **Dr. Roland B. Morrison,** Carroll physician for 42 years, retired January 1. Dr. Morrison received the M.D. degree at U. of I.

College of Medicine and interned in Chicago. He joined his father, the late **Dr. Orry C. Morrison,** in medical practice in Carroll in 1933. . . . **Dr. Garo A. Chalian,** Clinton, has been elected president of Iowa Urological Society. Dr. Chalian is a diplomate of the American Board of Urology and a fellow of the American College of Surgeons. He has practiced in Clinton since 1961. . . . **Dr. J. G. Angel,** Council Bluffs, has been elected secretary of North Central Region of the American Association for Clinical Immunology and Allergy at the group's annual meeting in Palm Springs, California. Dr. Angel also was recently named a Fellow of American Academy of Family Physicians. . . . **Dr. Henry J. Kaplan,** resident physician in ophthalmology at U. of I. College of Medicine, has been awarded a $2,500 research grant by Iowa Society for Prevention of Blindness, Inc. . . . **Drs. Harry W.** and **Marie Alcorn,** Mason City physicians, and **Dr. Robert G. Wilson,** Missouri Valley, recently received silver anniversary citations from Creighton University. All are 1950 graduates of Creighton University Medical School and were recognized for 25 years of service to mankind and loyalty to Creighton.

Dr. Martin Sands, associate professor, Department of Dermatology at U. of I. College of Medicine, presented a recent program for physicians, nurses and other health professionals at St. Joseph's Community Hospital in New Hampton. The program was sponsored by Minowa Area Health Planning Council, U. of I. College of Medicine and Mayo Foundation. **Dr. James Carr,** New Hampton, was local coordinator. . . . **Dr. Ralph Knudson** has been named student health physician of Luther College Health Service. A 1972 graduate of U. of I. College of Medicine, Dr. Knudson served his internship in Phoenix, Arizona, and residency at Lafayette Clinic in Detroit. . . . **Dr. Bruce Dunker,** Mason City, spoke at a recent meeting of Cerro Gordo County Panhellenic Association on innovations in obstetrics and gynecology. . . . **Dr. Gary Reams** recently opened a family practice in Blairstown. A graduate of U. of I. College of Medicine, Dr. Reams was formerly located in South Dakota. . . . **Dr. Gerald Solomons,** professor of pediatrics at U. of I. College of Medicine, directed a seminar on improving health services at annual meeting of the National Association of Partners of the Americas in Albuquerque, New Mexico. Dr. Solomons, chairman of the Iowa/Yucatan, Mexico Partners Committee, has developed programs in nutrition and early child development at University of Yucatan.

Dr. Joseph Rapagnani, a native of Keokuk, has returned to his home town and opened a solo family practice. For the past two years, Dr. Rapagnani has been in family practice in Fort Madison. . . .

DEATHS

Dr. Luther W. Loving, 84, Estherville, died November 6 at his home. Dr. Loving received the M.D. degree at University of Illinois School of Medicine in Chicago, and began his practice of medicine in Estherville in 1932. He served for many years on county and city health boards and was a life member of the Iowa Medical Society.

Dr. Elmer G. Senty, 84, former Davenport physician, died November 25 in St. Petersburg, Florida. Dr. Senty attended Rush Medical School and University of Minnesota School of Medicine. He was a Fellow of American College of Physicians and life member of the Iowa Medical Society.

Dr. Richard F. Looker, 54, Cedar Rapids, died November 28. Dr. Looker received the M.D. degree at University of Kansas Medical School and served his internship and residency in pathology at St. Francis Hospital in Wichita, Kansas. He was co-director of both the pathology department at St. Luke's and the hospital's school of medical technology. Dr. Looker was a past president of the Iowa Association of Blood Banks; a fellow of the American Society of Clinical Pathologists; and a fellow of the College of American Pathologists.

Dr. B. L. Knight, 82, retired Cedar Rapids physician, died November 30. A 1918 graduate of U. of I. College of Medicine, Dr. Knight was the first physician to intern at St. Luke's Hospital in Cedar Rapids. He was a life member of the Iowa Medical Society and a fellow of the American Academy of Ophthalmology and Otolaryngology.

Dr. William R. Hornaday, 85, Des Moines physician for 50 years, died December 2 at Wesley Acres in Des Moines. Dr. Hornaday received the M.D. degree at U. of I. College of Medicine. He also attended Mount Sinai School of Medicine in New York City and completed his residency in urology at Johns Hopkins University in Baltimore, Maryland. He was a member of American College of Surgeons and American Urological Association.

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cautions: If combined with other psy- tropics or anticonvulsants, consider efully pharmacology of agents em- yed; drugs such as phenothiazines, cotics, barbiturates, MAO inhibitors other antidepressants may potentiate action. Usual precautions indicated in ients severely depressed, or with latent pression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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President's Page

Do you have goals or objectives for your life? Or are you too busy to think about the question? Most of us would probably answer (1) to provide for and enjoy our families, and (2) to practice good medicine.

Let's look at the first part of the preceding answer. What constitutes being a family? Does 30 minutes together at dinner? Does being in church on Sunday morning? Does a two-week summer vacation? They all help, but a family they do not make.

Togetherness is the distinguishing mark of a family. And togetherness requires thoughtfulness, love, communication and understanding every hour of every day. Admittedly, this idea of togetherness is not easy for a busy physician, but it is a MUST. All too often we compromise on these matters; we put them off to be accomplished later, but later never arrives.

Family communication is so important. Do you really communicate with your family—especially your spouse? If family communication is dormant, questions remain unanswered and problems unresolved—little problems become little mole hills and little mole hills eventually become mountains—then we no longer live as a family.

Physician heal thyself. Put your first goal first and get some happiness into your life. Don't wait 20 years to communicate with your family—it's too late then.

Perhaps we should have a psychological check-up as well as a physical check-up. This might help us assess our progress toward family togetherness. It's food for thought.

Sincerely,

V. L. Schlaser MD

V. L. Schlaser, President

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The Question Box

by ROBERT D. WHINERY, M.D.

IMPAC IN 1976

Dr. Whinery is chairman of the Board of Directors of the Iowa Medical Political Action Committee. He comments here on the 1976 election blueprint of IMPAC.

1976 is a national election year. What will be the role of IMPAC in the next few months?

IMPAC's primary role will continue to be that of increasing its membership, both with regular IMPAC membership and those of Victory '76. Since IMPAC's role is that of financial campaign support, increasing its membership then increases its monetary resources and hence, its effectiveness. Secondly, IMPAC will be actively encouraging Iowa physicians to organize campaign support committees and will provide the know-how to carry this out. Lastly, our job in the next months will be that of candidate identification. We must view and evaluate the candidates running for office and select those to be supported.

How important is it for the medical profession to support good candidates through a mechanism such as IMPAC?

We must be able to have input to our State and Federal legislators if our point of view is to be understood. It must be emphasized that we in no way can "buy" legislators, for if that were possible we would certainly be outbid by other groups. Whether or not one is in favor of the present political process and campaigning as such, the fact remains that this is our present system and the cost to a candidate is staggering. These costs must be borne by those people favoring his views and it is our job to support candidates that seem sympathetic, or at least willing to listen, to the aims of good medical care.

It is the IMPAC theory that a large contribution of several hundred dollars is more meaningful to a candidate, since it represents a combined contribution of many doctors in his district, rather than an individual contribution alone. We certainly do encourage members to contribute individually, in addition, if they so desire.

Many candidates are aware of IMPAC and those who are friends of medicine have often asked for our financial assistance in their campaigns.

It is apparent to all of us that there is a myriad of potential legislation related to health care, especially those now concerning professional liability and the further socialization of medicine. It is most essential that our voice be heard concerning these. Other allied medical or pseudo-medical professions give many times over what we do for political campaign candidate support.

What process is used to determine which candidates IMPAC will support in an election campaign?

The final selection of candidates to be supported is made by the 22-member IMPAC Board of Directors. This includes 19 physicians and 3 members of the IMS Auxiliary. Those persons on the IMPAC Board of Directors are selected for their political knowledge and interest as well as their geographic distribution. By reviewing the performance records of incumbents and by candidate interviews, as well as input from the Iowa Medical Society lobbyist, these selections are made. It must be emphasized that IMPAC is nonpartisan and that, heretofore, both Republican and Democratic candidates, where appropriate to medicine's interests, have been supported. IMPAC has never

(Please turn to page 57)

RARE TYPE OF SHIGELLOSIS

A case of illness due to *Shigella dysenteriae* Type 1 was reported from Colorado in October of 1975. This particular type of shigella organism only rarely causes illness in the United States, while *Shigella sonnei* and *Shigella flexneri* are very frequently pathogens in this country. *Shigella dysenteriae-1,* known as the Shiga bacillus, is well worth differentiating from other members of the Shigella group in that its infections are associated with more severe illness and a higher mortality rate, and because the extreme rarity of its occurrence in this country makes it practical to search for the source of introduction and chain of transmission to each individual case.

The Colorado report and discussion is reprinted below.

SHIGELLA DYSENTERIAE-1: RECENT COLORADO CASE

A 5-year-old boy from Byers became ill with fever and diarrhea on September 29, 1975. The next evening he was examined by a physician who prescribed Lomotil, acetaminophen, and an anti-emetic. Over the next 3 days the boy's symptoms persisted, and his mother noticed small amounts of blood in his stool. She telephoned the physician who prescribed an electrolyte solution. On October 4, the boy's stool was grossly bloody, and the 3 other family members developed fever and bloody diarrhea.

On October 5, the entire family was hospitalized. Physical examination of the boy showed him to be restless but with good skin turgor and without other apparent signs of dehydration. Admission laboratory work revealed, in mg/100 ml, a sodium of 108, potassium 7, chloride 66, bicarbonate 28, and a venous pH of 7.48. The white blood cell count was 51,000 with a large shift to the left, and the hematocrit was 43%. Treatment consisted of fluid replacement using IV normal saline. Ten hours after admission, the boy suffered a cardiopulmonary arrest after aspiration of vomitus and could not be resuscitated. Both stool and blood cultures on the boy subsequently grew out *Shigella dysenteriae-1,* sensitive to ampicillin. The same organism was also isolated from the other 3 family members.

The family had not traveled out of the country, but they were close friends with a family of 3 who had recently returned from Afghanistan. While traveling there, this family's 2-year-old boy developed diarrhea and fever on July 20 and continued to have diarrhea intermittently despite treatment with penicillin. After his return to Colorado he continued to have intermittent diarrhea until early October when his illness resolved spontaneously. Cultures of a rectal swab obtained from the child on October 8, when he was asymptomatic, grew *S. dysenteriae-1.* Rectal swabs from the other 2 family members, 20 contacts of both families, and 6 other residents of Byers who had had recent diarrheal illnesses did not grow the organism. None of these persons recalled having had diarrhea for more than 2 days since September 15.

Editorial Note

S. dysenteriae-1, or Shiga's bacillus, characteristically produces a more severe illness than that caused by other shigellae. Although some strains of *S. dysenteriae-1* produce a toxin, the organism causes disease by penetrating the intestinal epithelium and causing subsequent tissue destruction.[1] This disease is characterized by abdominal cramps, profuse diarrhea, dehydration, and fever often followed 2-3 days later by tenesmus with frequent bloody, mucoid stools.[2] In one study, 7 of 20 (35%) hospitalized patients had positive blood cultures.[3] Lomotil has been recent-

ly shown to have an adverse effect on the course of shigellosis.[4]

S. dysenteriae-1 is rare in Western Europe and the United States, but little is known about its prevalence in other parts of the world. Most cases in Colorado are seen in persons returning from Mexico or in those having contact with these travelers. The 2-year-old index case in this report probably acquired his infection in Afghanistan and spread it to his mother and 5-year-old playmate.

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SOURCE: Colorado Weekly Communicable Disease Summary; Vol. III; Issue 44; November 1, 1975.

Morbidity Report for December, 1975

Disease	Dec. 1975	1975 to Date	1974 to Date	Most December Cases Reported From These Counties
Amebiasis	12	32	34	Boone, Linn, Polk
Ascariasis	3	20	11	Story, Washington, Wright
Brucellosis	3	25	29	Dubuque
Chickenpox	1364	9543	8748	Cass, Dubuque, Polk, Pott.
Conjunctivitis	128	1402	1198	Black Hawk, Humboldt
Clonorchis sinensis infestations	1	1		Story
Encephalitis				
due to CEV	2	11		Black Hawk
due to SLE	4	15		Benton, Clark, Polk, Woodbury
assoc/with Herpes infection	1	6		Polk
assoc/with ECHO 4	1	11		Woodbury
assoc/with ECHO 19	1	1		Linn
due to ECHO 6	1	2		Sac
due to ECHO 9	1	3		Winneshiek
Erythema infectiosum	13	211	593	Bremer, Butler
Gastrointestinal viral infect.	3960	25555	20120	Audubon, Carroll, Floyd
Giardiasis	5	30	44	Boone, Des Moines, Hardin
Hepatitis,				
A (infectious)	35	202	270	Black Hawk, Iowa, Scott
B (Serum)	7	93	91	Black Hawk, Scott
type unspecified	2	31	56	Polk, Woodbury
Impetigo	87	948	710	Scattered
Infectious Mononucleosis	121	1314	1204	Johnson, Polk, Scott
Influenza-like illness	4251	50800	106977	Bremer, Buchanan, Polk
Meningococcal Meningitis	1	8		Polk
Meningitis type unspecified	2	31	46	Pottawattamie
assoc/with ECHO 4	1	4	16	Jackson
assoc/with ECHO 9	1	1		Scott
assoc/with *H. influenzae*	3	18	7	Louisa, Scott, Woodbury
Meningoencephalitis assoc/with ECHO 4	2	3		Dubuque, Linn
assoc/with ECHO 9	1	1		Scott
Mumps	127	1514	1985	Scattered
Pediculosis	35	440	742	Black Hawk, Cedar, Scott
Pertussis	20	24		Des Moines, Lee, Taylor
Pinworms	1	42	65	Wapello
Pneumonia	69	1122	1015	Buchanan, Scott
Rabies in Animals	3	101	130	Dubuque, Johnson, Scott
Ringworm, body	38	333	280	Scattered
scalp	1	11	19	Black Hawk
Rubella	2	31		Sioux
Rubeola	38	717		Dubuque, Polk
Salmonellosis	8	191	191	Scattered
Scabies	108	745	236	Black Hawk, Dubuque, Polk
Streptococcal infections	1273	10357	10562	Jackson, Johnson, Polk
Tuberculosis, total ill	7	126	115	Scattered
bacteriologically positive	7	88	15	Scattered
Trichuriasis	2	15	6	Fayette, Wapello
Venereal Diseases				
Gonorrhea	622	7200	6481	Black Hawk, Linn, Polk, Scott
Syphilis	28	308	372	Black Hawk, Linn, Polk

Laboratory Virus Diagnosis Without Specified Clinical Syndrome

Adenovirus infect. 1, Cytomegalovirus 1, Eaton's agent inf. 4, ECHO infect. 3, Herpes simplex 5, Herpes Zoster 1

1776 MEDICINE SIMPLE AND PRIMITIVE

The bicentennial commemoration deserves reference to the pioneer physicians. This feature on the history of American medicine was prepared by the American Medical Association.

MEDICAL CARE in the American colonies in 1776 was a crude and primitive affair compared to today's highly developed health care system.

In fact, for many Americans, there just weren't any doctors at all, and home medicine was the only answer. Most of the nation lived in remote rural areas. The crisis was over—the patient either survived or died—before the doctor could arrive on horseback.

And if you did find a doctor, his knowledge and his tools and medicines were scant indeed compared to today's sophisticated and scientific medicine. The doctor likely had never attended medical school and had no license to practice medicine. He didn't really know what caused most diseases and he didn't really know how to treat them.

The doctor's answer to disease in those days was likely to be to open a vein in the wrist and draw off a pint or two of blood . . . or a dose with a very strong emetic to induce vomiting . . . or a strong purgative to cleanse the bowels. Often the treatment did more harm than good.

The doctor didn't know about germs and how to prevent infection. Pasteur and Lister were still far in the future. He did know that inoculation against smallpox gave protection, and the Continental Army was well protected against this scourge.

The doctor had—sometimes—a few items to relieve pain—alcohol, opium, laudanum. *He had no penicillin, no insulin, no vaccines, no anesthetics.*

There were about as many doctors for the population 200 years ago as there are today—one to 600. At the time of the Revolution there were around 3,500 fairly legitimate medical practitioners in the thirteen colonies. Less than 400 of these possessed medical degrees. Most had been trained under the apprentice system. A very few were products of European medical schools, or one of the two new American schools.

In colonial times, the aspiring physician apprenticed himself to an older doctor, served several years, and received from his mentor a certificate certifying his competence to practice medicine.

Surgery consisted largely of amputations of injured arms and legs. Many of the patients died of infection and loss of blood. *The doctor had to get by without most of today's common medical tools —clinical thermometer, stethoscope, hypodermic syringe.*

Colonial physicians used a variety of drugs when they could get them, such as "Jesuit's Bark" (quinine) for fevers, and they drew heavily on the native plants and shrubs. Knowledge of therapeutic plants, gained through generations of experimentation, was considerable, and could aid in relieving pain and in curing some diseases.

Fevers, smallpox and dysentery caused much of the illness. Life expectancy was short and the degenerative diseases of advancing years were a minor health problem for most Americans in 1776. Dirt and poorly cooked food and drink made dysentery a highly common health problem in the Continental Army. Influenza and pneumonia were common, thriving on poor ventilation, crowded conditions, dirt and poor diet.

Despite their handicaps, American doctors did the best they could and their very presence was a great help to many sick individuals. The doctor was a prominent man in his community and several physicians were among the signers of the Declaration of Independence: Josiah Bartlett of New Hampshire; Lyman Hall of Georgia; Benjamin Rush of Pennsylvania; Matthew Thornton of New Hampshire, and Oliver Wolcott of Connecticut. Others were members of the Continental or United States Congresses.

IN THE PUBLIC INTEREST

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ADVERSE REACTIONS: Drowsiness and dryness of the mouth are occasionally associated with antihistamine therapy in some individuals.

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The above represents a brief summary. See package inserts for full prescribing information.

Educationally Speaking

by RICHARD M. CAPLAN, M.D.

REPAYING THE DEBT

Had you ever thought of yourself as paying a debt by reading a journal, or discharging a moral obligation by attending a continuing education course? Paying a debt you owe to whom? For what?

The answer is: paying a debt to our patients for allowing themselves during their times of travail and illness to be the substrate of our learning process. This is not to suggest, pejoratively, that the patient is a "guinea pig" to some sort of wanton and needless experimentation. But in a much finer sense the physician-patient interaction is always an experiment—a trial to test an hypothesis about the relationship of patient to disease to therapeutic intervention. Each patient visit, then, is an episode of clinical investigation. Biological inquiry always relates to a living organism. If we use mice, rabbits or monkeys, we must pay for them. If we use bacterial colonies or chimpanzees, we must pay. Within our ethical system we can "buy" the services of cooperating subjects (often medical students) only for some small number of experiments where the risk to the healthy subject is trivial. Yet our most crucial and useful research must take place in human subjects who bear the burden of some sort of disorder, but who can and are willing to lend their cooperation, their physiological factories, their very continued existence to our interventions.

The great proportion of such investigation takes place not at the basic science laboratory bench nor in large medical centers. Rather, the kind of investigation I speak of takes place mainly away from such centers. It is the day-to-day practice of clinical medicine that is the setting for these immense experiments. From our patients we learn about disease, about therapeutic responses, and about how to conduct our affairs as we practice medicine. We must buy hamsters if we would use them, yet our patients come to us unbought and essentially unbuyable. This circumstance suggests the accumulation of a massive obligation that moral beings feel obliged to discharge.

Judah Folkman, surgeon-in-chief at Boston Children's Hospital, has urged us to ". . . appreciate the debt we owe our patients for our education. It is a debt we must repay—it is like tithing. . . . We can repay the debt in many ways. We can attend postgraduate courses and seminars, be available to patients at all hours, teach, take recertification examinations. . . . We have wide opportunities to tithe. Compassion is one, but there are also all the other qualities I have mentioned by which a physician should repay his patients for his own education. . . ." Then he can say with peace of mind that he is earning the right to *practice* medicine.

I do not wish to induce in practitioners a sense of guilt that they are to expiate by participating in continuing education endeavors. Continuing education should be approached with a positive attitude. Yet the sense of discharging a moral obligation to our patients and our society is not an unwelcome nor inappropriate reason for continued pursuit of learning and skill.

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SCIENTIFIC ARTICLES

A Comprehensive Program in Iowa For Patients With Epilepsy

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Over 1,500 epileptic patients from 98 of Iowa's counties were seen at University Hospitals in 1973. This statistic underscores the importance of maximizing the diagnostic and treatment resources which are available. This paper advocates support for the family practitioner in his care of the epileptic patient.

Epilepsy is a significant medical problem. Conservative estimates place the incidence at 0.5% of the general population. This would indicate at least 14,000 individuals are affected with this condition in the State of Iowa. Over 1,500 such patients were seen at the University Hospitals in Iowa City in 1973. Individuals were seen from 98 of Iowa's 99 counties.

A feasibility study* of a comprehensive epilepsy program has been completed recently in the Department of Neurology of the College of Medicine at the University of Iowa. Effort was made to outline the criteria necessary for establishing a comprehensive program in an urban-rural area. This included an evaluation of medical care, vocational and educational opportunities, and other social, economic, and psychological conditions that affect epileptic patients within our geographic area. A model to investigate the incidence and demographic characteristics of epileptics was proposed. One of the primary goals of the study was to develop plans for clinical research in the diagnosis, history, treatment, and prevention of epilepsy. A survey was made of existing resources (personnel, services, facilities and equipment, etc.) which included both professional and lay organizations concerned with epilepsy. Programs were developed for improved training and education of physicians and other professionals to make them aware of the newest advances in epilepsy treatment and research. It also included emphasis on a broad program of public education.

An improved utilization of presently available facilities was emphasized, although proposals for future projects were outlined as well. While the University of Iowa did not receive one of the

The authors are associated with the Department of Neurology at the University of Iowa College of Medicine.
The project described was supported by NINCDS-NO1-NS-4-2318 Contract Feasibility Study for a Comprehensive Epilepsy from the National Institutes of Health.
* One of 11 feasibility studies was awarded to the Department of Neurology of the College of Medicine of the University of Iowa.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF FEBRUARY, 1976.

three recently awarded Comprehensive Programs in Epilepsy, some definite insights into epilepsy have been gained from this study. This article will relate those aspects of care, education, and research in epilepsy that are presently feasible or operational within the State of Iowa.

MEDICAL CARE

A special treatment center (or centers) for epilepsy was considered, but various practical problems cast doubt on this possibility. Fundamentally, no such centers now exist, and both the staffing and the cost of establishing such centers restrict the feasibility. Should these hurdles be cleared, there remains the problem of distance between an established center and the patient. The personal insight and relationships that can be developed most readily in the family practice setting might pose an additional problem for the center's approach to epileptic care. Accordingly, we have favored the family practitioners as the basic providers of care for patients with epilepsy. This seems only logical since this is indeed the usual way in which patients seek care for their epilepsy.

This also is important in terms of the required follow-up care that epileptic patients must have. The physician on the scene at home is best able to attend to the day to day progress of the epileptic patient, to look out for problems in drug toxicity or the rare idiosyncratic response to anticonvulsant therapy and to know and understand those personal problems of the patient that can so dramatically affect seizure control. When problems in diagnosis or treatment appear, the currently established referral pattern between the family practitioner and University Hospitals can be utilized for the consultative help appropriate to the problem.

Criticisms of this approach to treatment in epilepsy have been raised by some patients. These individuals point out difficulty in finding a family physician, or in finding one who is interested and experienced in treating seizures. While such situations may exist, it still appears the best treatment approach for the greatest number of epileptic patients is through the family practitioner. Continuing education programs on epilepsy will help improve skills in treatment. Recognition of the progress which has been made in drug therapy of the epilepsies with the use of serum anticonvulsant levels should enhance both enthusiasm and accomplishments in therapeutics.

Additional assistance in patient care is available through the State Services for Crippled Children, as periodic clinics are scheduled throughout Iowa. Another source of patient care is represented by the variously located Family Practice Clinics which are involved in training programs through the Department of Family Practice at the University of Iowa. Skilled nursing services are provided by public health nursing staff (Division of Community Health of the State Department of Health in 90 of Iowa's 99 counties). Further treatment for patients whose medical problems include epilepsy is provided in the State Mental Health Institutes (Cherokee, Clarinda, Independence, Mt. Pleasant), the various mental health centers, and the State Hospital Schools (Woodward and Glenwood).

LABORATORY FACILITIES

Certain diagnostic facilities are necessary in the diagnosis of the epilepsies. Electroencephalographic testing is crucial and available in several areas, including the University Hospitals. Standard radiographic procedures are supplemented in a variety of areas with the capability of accomplishing radionuclide brain scans and various contrast studies of the brain (arteriography and pneumography). A special computerized radiographic examination of the head (EMI or computerized axial tomography scan) is available at the University Hospitals in Iowa City to aid in diagnosis. Laboratory facilities are found throughout the state with the capability of accomplishing the hematologic and biochemical testing needed for routine evaluations of potential toxicity in anticonvulsant therapy. Similar capabilities in diagnostic tests of etiology, such as hypoglycemia, are available.

An important step forward in the treatment of patients with epilepsy has been the utilization of serum anticonvulsant levels. A laboratory for determining these values was established in the Department of Neurology at the University of Iowa in 1972. The determinations were initially accomplished by gas chromatography which has been recently supplemented by the use of an immunoenzyme assay. Increasing availability of such accurate serum anticonvulsant levels (a matter of critical importance), along with increasing insights by medical practitioners in their use in adjusting anticonvulsant dosage, will certainly improve the correct utilization of antiepileptic medications. Serum levels permit maxi-

mum efficacy of a single medication and can reduce the complications attendant with polypharmacy.

MEDICAL RECORDS

Well-kept records are especially important in the care of patients with epilepsy. Repeated progress evaluations are necessary: (1) to assess the patient's response to drug therapy, (2) to look for drug toxicity (and rarely idiosyncratic response), (3) to reconfirm the diagnostic impression (any progressive neurologic or systemic abnormalities appearing to indicate an etiology different than the initially suspected cause), 4) and to document the patient's progress with regard to personal, vocational, and social needs that can be significant problems for individuals with epilepsy.

A systematic approach to this type of record maintenance has been developed as a special record (with the invaluable assistance of Systems Development, University Hospitals, University of Iowa) and the usefulness of this type of record in patient care is being appraised presently. It is our hope this format for recording and retrieval of essential information will provide for rapid availability of pertinent information and enhance both the speed and accuracy of therapeutic decisions in treating patients with epilepsy.

CLINICAL RESEARCH

Particular emphasis was assigned to clinical research in the feasibility studies. This, along with emphasis on training and education for physicians and other professionals, prompted the National Institutes of Health to favor awards for the feasibility studies to organizations closely related to medical schools.

Clinical research in the drug therapy of epilepsy was begun in the Department of Neurology in Iowa City in 1972 when this department purchased a gas liquid chromatograph and equipped the departmental laboratory in such a way that measurement of anticonvulsant (diphenylhydantoin, primidone, phenobarbital) serum and cerebrospinal fluid concentrations could be measured.

The ability to measure these serum anticonvulsant concentrations has significantly improved our ability to treat patients with epilepsy. Three kinds of unusual patient responses to anticonvulsant drugs became apparent as these tests were employed in caring for epileptics. Some individuals who have shown inadequate response to standard doses of anticonvulsant medication were found to have suboptimal serum concentrations and their improved response to medication was effected by the simple expedient of increasing the dose of anticonvulsant medication.

Another group showed toxicity on standard doses of medication. Improvement was achieved by dose reductions with maintenance of at least as satisfactory seizure control.

A third group of patients showed satisfactory serum concentrations of antiepileptic drugs but an unsatisfactory response in terms of seizure control. The reasons underlying these basic differences in patient response to drug therapy are at best only partially understood and the cause or causes of the third kind of response (or better lack of response) is simply unknown.

Serum anticonvulsant measurements have opened a new world of insights with respect to drug interactions. An example we have observed relates to the interaction of diphenylhydantoin (Dilantin®) and primidone (Mysoline®). Primidone usually converts, in vivo, to a certain extent to phenobarbital. The concurrent use of diphenylhydantoin with primidone enhanced this conversion by a factor of four and frequently led to clinical states of phenobarbital toxicity, especially in those patients who were also receiving phenobarbital. Another more dramatic example of drug interactions was suggested by a precipitous fall in serum diphenylhydantoin concentrations (from 21 mcg/ml to 3 mcg/ml) in a patient that led to a bout of status epilepticus. This fall in serum anticonvulsant concentration occurred despite the fact that the patient had continued her customary oral dose of medication which previously had afforded adequate serum levels of the drug and clinical seizure control. We postulated that the concurrent use of an oral antibiotic impaired absorption of the anticonvulsant and brought about the inadequate serum concentrations of diphenylhydantoin. The serum levels enabled us to treat effectively the bout of status epilepticus by increasing the oral dose of anticonvulsant during the patient's period of antibiotic therapy. Clearly, much work needs to be done in delineating and understanding the nature of drug interactions in anticonvulsant therapy.

Several clinical research projects were proposed in our model for a comprehensive epilepsy program. Among these projects were several

which involved detailed studies of metabolic profiles in various body fluids from individuals presenting with different symptomatologies occurring in epilepsy. These metabolic profiles would have to be obtained utilizing gas-liquid chromatography coupled with mass spectrometry. These projects will not be feasible until the necessary financial support can be obtained to purchase the required equipment. In the interim we will pursue the clinical studies of antiepileptic drugs possible with present laboratory and financial resources.

PSYCHOSOCIAL, VOCATIONAL, AND EDUCATIONAL ASPECTS OF EPILEPSY

The ultimate aim of medical therapy for epilepsy is to obtain predictable and complete control of the patient's seizures without toxicity. The achievement of these goals for all epileptics is still a distant prospect. In the interim, patients with epilepsy must pursue their lives in the best way they can. They have needs for various kinds of support. These needs will vary with the particular patient.

Epilepsy has not been a "popular" condition for general support. Fear and revulsion have characterized the public response much more often than have sympathy or understanding. An important beginning is being undertaken in public education. Lay groups (Aligned Community of Epileptics, Waterloo; Eastern Iowa Epilepsy Association, Dubuque; Siouxland Epilepsy Association, Sioux City; Epilepsy Association of Area X, Cedar Rapids; and Epilepsy Society of Area XI, Des Moines) have sponsored educational programs dealing with various problems faced by patients with epilepsy. In Iowa, numerous public and private agencies have responsibility for serving the educational, vocational, and psychosocial needs of the handicapped. Several agencies involved in the feasibility study acknowledged the needs of the professional and paraprofessional, for in-service training, and for a more comprehensive service approach. In addition to the need for in-service training to present the unique difficulties which epileptics confront, the following general impressions were made: (1) services are not uniformly accessible on a statewide basis; (2) some professionals' attitudes are not unlike those of the general public; (3) and many epileptics, particularly those with the single handicap, do not qualify for some services, nor do the existing services satisfy their needs. During our study a complete survey was made of the existing personnel and facilities available for social, rehabilitative, educational, vocational, and types of residential services in the State of Iowa.

The Iowa Department of Public Instruction is planning efforts to increase the understanding of school teachers and administrators about epilepsy so they may better assist their pupils who are epileptic. Efforts of this kind will with time lead to the public support that epileptic patients both need and deserve.

The Iowa Department of Social Services offers a host of services which may benefit individuals with seizures (medical services, income maintenance, counseling and residential services). Vocational rehabilitation services are available to patients with epilepsy throughout the State of Iowa. This includes three Vocational Rehabilitation Evaluation Centers. Sheltered workshop/work activity centers provide a remunerative setting for persons who cannot successfully obtain or maintain competitive employment. Increasing insight into the nature of epilepsy by employers should lead to an increasing ease of employment for patients. Increasingly effective medical treatment of cerebral seizures will ultimately afford the best opportunity for vocational and social rehabilitation of the epileptic patients.

Education of current and future professional and paraprofessional personnel who must provide care for the epileptic patient is a current and continuing effort in the various departments of the College of Medicine. Additional funds will allow expansion of these programs to provide postdoctoral training in highly specialized areas.

SUMMARY

Although a federally funded comprehensive epilepsy program has not been established in Iowa, a number of presently available resources will allow the accomplishment of many aspects of such a comprehensive program.

Medical care is provided basically by Iowa family practitioners. Support for these physicians comes from a variety of sources, including crippled children clinics, family practice clinics, various medical and surgical specialists including those at the University Hospitals and Clinics in Iowa City. In this manner, medical problems of an unusually difficult nature can receive the necessary expert attention. Maximal utilization of the statewide social, vocational, rehabilitative, volunteer, and educational services will add support to the non-medical needs of the patients with epilepsy.

(Please turn to page 62)

Case Report: Seminoma Testis With an Unusual Mode of Dissemination

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An atypical case of seminoma is reported. Spread to the para-aortic lymph nodes did occur, but then disseminated quickly via the blood stream into the bones and skin, skipping the lungs and the mediastinum. Seminoma is characterized as the most radiosensitive of the testicular malignant tumors.

Seminoma is a germ cell tumor which when compared with the incidence of other testicular teratoid tumors is the most frequent. It occurs more commonly in the fourth and fifth decades of life and is relatively less malignant. Seminoma is a tumor of high radiosensitivity.

Seminoma constitutes 40% of the malignant testicular tumors. Histologically, seminoma has been subclassified into the classical form, anaplastic seminoma, and the spermatocytic variety.[1]

Spermatocytic seminoma makes up less than 10% of all seminomas. It occurs in a distinctly older age group than does the classic seminoma and does not appear in association with teratoma. It seems to have an even better prognosis than classic seminoma.[2]

The age factor not only influences the frequency of any particular type of testis tumor, it may also bear on the behavior of the tumor. However, data is not yet sufficient on these points to permit useful generalization.[2]

Microscopically, seminomas are readily recognized because of their monocellularity. The cells are moderately large; round, cuboidal, or polyhydral in shape; and quite uniform in size. Mitotic figures are infrequent. In about 10%, however, there is considerable anaplasia and increased mitotic activity (anaplastic seminoma) indicative of a more aggressive tumor.[3]

Typical seminoma has an excellent prognosis and, properly treated, should have a 95% five-year survival rate. Most of the seminomas that metastasize and terminate fatally belong to the category of anaplastic seminoma.[4]

Seminoma spreads mainly by lymphatic routes. The first site of spread is the regional lymphatics, that is the para-aortic and para-caval lymph nodes in the lumbar region just at or below the level of the renal veins. Other sites of lymphatic metastasis include: 1) lymph nodes at the junction of the left spermatic veins and left renal vein which fill directly from the left testicular lymphatics; 2) the low para-aortic nodes, and 3) occasionally in cases of massive disease, external or common iliac lymph nodes.[5] While there is some drainage to the common iliac nodes, the main drainage is directly to the para-aortic region. Here there is a vast lymphatic network with free communication between the two sides. From there the thoracic duct ascends to the left supraclavicular fossa, then it spreads to the mediastinum and lungs.[6]

The inguinal lymph nodes may also be involved if the patient has had previous surgery through the scrotal skin, for example, herniorraphy, biopsy, or orchidopexy. In advanced cases, the patient may have disease already spreading to the mediastinum, supraclavicular lymph nodes (mostly on the left side), and the lungs.[7]

The most common sites of involvement are the

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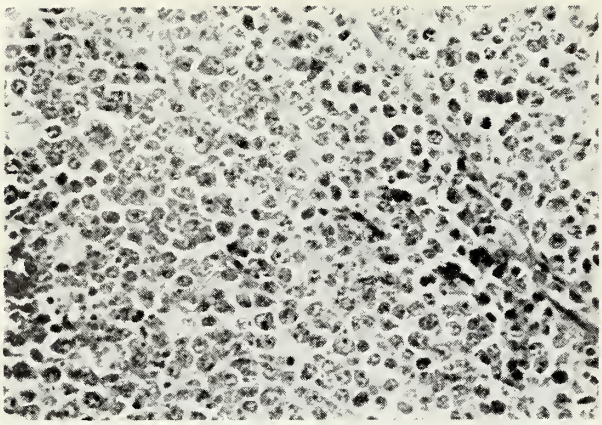


Figure 1. Primary tumor of the testicle.

aortic and iliac lymph nodes (71%), liver (54%), right and left lung (each 57%), right kidney (6%), left kidney (37%), right adrenal (9%), left adrenal (35%), pancreas (21%), peritoneum (22%), and mediastinal lymph nodes (17%).[4] Seminoma usually metastasizes as seminoma, but in few instances it may metastasize as embryonal carcinoma, teratoma, or choriocarcinoma.[4] This natural lymphatic spread of testicular tumors holds true in all cases except for choriocarcinoma which has a vascular spread.[2, 8, 9] The pattern of spread, once in the blood stream, is usually to the lungs.[8]

Several atypical metastatic possibilities have been reported which, although rare, do occur on occasion. The following is a case report of a seminoma which did spread to the para-aortic lymph nodes but then disseminated very quickly via the blood stream into the bones and skin, skipping the lungs and the mediastinum.

CASE REPORT

A 68-year-old white male developed tender left scrotal swelling with fever in 1966. This was diagnosed as left epididymitis. It was treated by antibiotics with disappearance of the swelling.

A suspicious mass was found in the right testicle in 1971; a right orchiectomy was recommended, but the patient refused surgery, but in December 1972 a right inguinal orchiectomy was performed because of a sudden increase in size of the right testicle. No abdominal extension could be palpated at the time of surgery. The pathology report showed pure seminoma with extensive invasion of the epididymis and spermatic cord (Figure 1). Tumor was found in the resection margin of the spermatic cord. Lymphangiogram showed involvement of the right iliac lymph nodes and left para-aortic lymph nodes. The right para-aortic lymph nodes were suspicious (Figure 2). Chest x-ray was normal.

Figure 2. AP view of a bipedal lymphangiogram showing the iliac and para-aortic groups of lymph nodes showing involvement of the right iliac and left para-aortic lymph nodes.

Figure 3. Peri-apical radiograph of the maxillary left lateral incisors and canines.

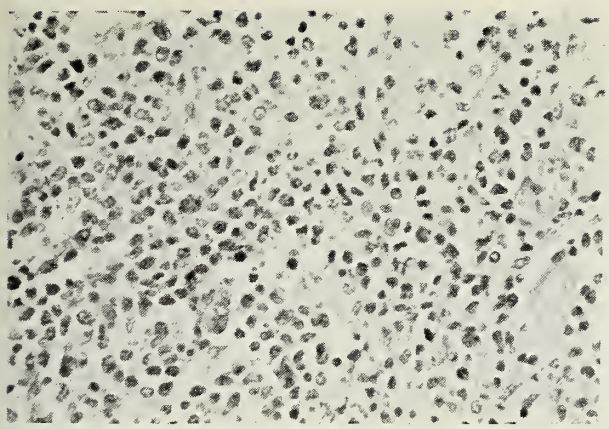


Figure 4. Metastatic tumor of the maxillary alveolus process.

The right one-half of the pelvic cavity, right groin, right one-half of the scrotum, and both para-aortic lymph node chains were irradiated using cobalt-60 teletherapy through anterior and posterior parallel opposed hockey stick shaped ports. The upper margin of the port was at L1. A total tumor dose of 3,600 rads was delivered from 10 January 1973 through 12 February 1973.

The plan was to have the patient return in one month for irradiation of the mediastinum and left supraclavicular area. However, the patient experienced throbbing pain between the left maxillary lateral incisors and canines and was seen by an endodontist and a periodontist. His general condition was poor. Abscessed teeth were suspected and treated with antibiotics with no response.

On 2 March 1973 an ill-defined, hard swelling was found in the maxillary left canine region which extended to the hard palate. A smaller swelling was noticed on the lingual surface of the mandibular alveolus in the region of the left incisors. There were x-ray manifestations of osteolytic involvement of the maxillary alveolus region (Figure 3). The maxillary lesion was biopsied and the pathology report showed pure seminoma (Figure 4). An enlarged left supraclavicular lymph node and a left midcervical lymph node were also detected at that time.

The patient began to complain of pain in his neck with numbness and weakness in both upper extremities on 5 March 1973. X-rays of the cervical spine showed a destructive lesion of C5 (Figure 5). He was also diagnosed as having both brachial plexus infiltrated with tumor. Anterior and posterior "opposing yoke" ports were used to irradiate the neck, both supraclavicular and subclavicular regions including C5 with cobalt-60 teletherapy. This port measured approximately 11 cm in length and 26 cm in width and extended from C3 down to below the clavicles. This volume of tissue received a total tumor dose of 3,570 rads in 23 days. Chemotherapy in the form of Chlorambucil was started, 4 mg, q.i.d.

The patient also developed pain in the right leg, and x-rays revealed evidence of a lytic lesion in the lower one-half of the right fibula (Figure 6). This was treated palliatively with radiation therapy to a total tumor dose of 3,000 rads in two weeks from 14 March 1973 through 28 March 1973. On 22 March 1973 the patient developed two subcutaneous nodules in the left arm measuring 3 x 3 cm and 2.2 x 2.2 cm.

The patient expired on 23 May 1973. The chest x-ray (as of 13 April 1973) continued to remain free of pulmonary or mediastinal metastases.

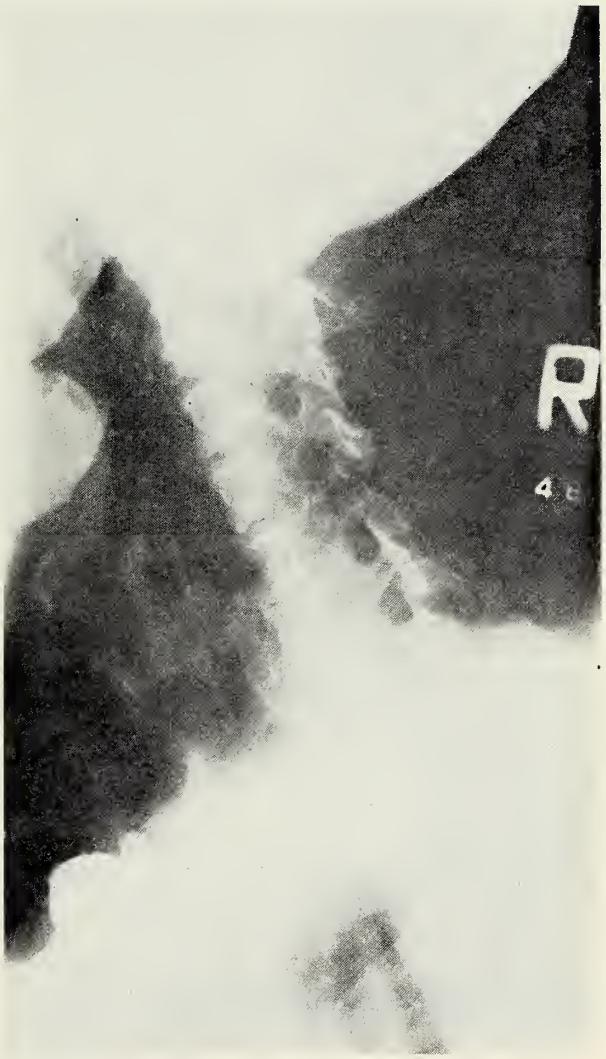


Figure 5. X-ray of cervical spine; destructive lesion of C5.

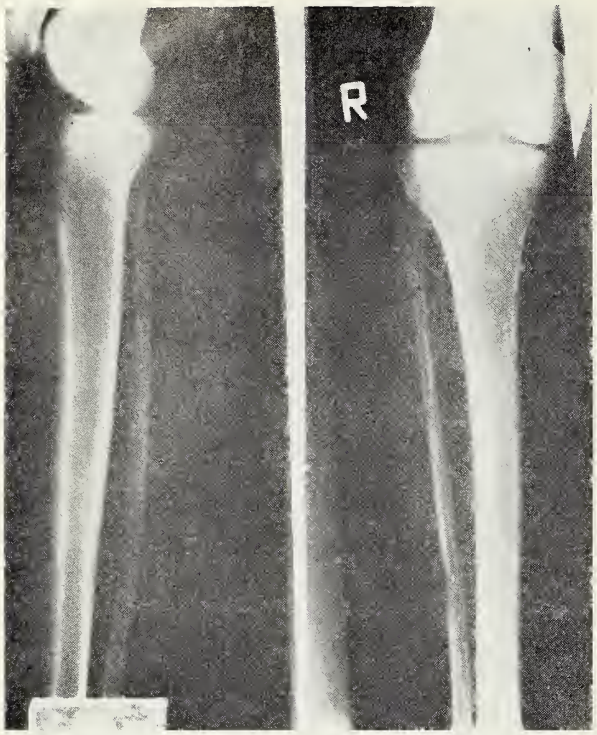


Figure 6. X-ray of right leg; lytic lesion in the lower one-half of the right fibula.

DISCUSSION

The atypical spread of this seminoma and the occurrence in old age made this case unusual. Although the lymphangiogram showed involvement of the right iliac lymph nodes and the left paraaortic nodes, the next metastatic site was neither the mediastinum nor the lungs but into the alevolar bones of the jaws which is extremely rare.[10, 11] This was rapidly followed by clinical and radiological manifestations of osteolytic metastases in the cervical spine and right fibula. The patient subsequently developed skin nodules in the left arm. There continued to be no radiologic evidence of mediastinal nor pulmonary deposits. This indeed represents an atypical course of the disease. Since there was no autopsy we feel the lymphovenous anastomosis and/or anomaly of the thoracic duct could have been the etiologic factor.[12]

Blood vessel invasion may be observed with any type of tumor but is most common with choriocarcinoma and least common with teratoma and seminoma.[2] It is possible for tumor cells to pass through lymphatic vessels into the venous circulation and then to the lungs without ever passing through a lymph node. The direct vascular route of spread is possible in any case of testicular carcinoma. However, most of such patients also have lymphatic metastases.[9] Roentgenographic evidence of bone metastases can occur before there is evidence of lung metastases.[13]

Lymphatic metastases are common to all germinal tumors.[2] The first lymph node station is in the lumbar region. From these retroperitoneal lymph nodes, dissemination is most commonly by way of the thoracic duct into the left supraclavicular lymph nodes and then into the subclavian vein, but the possibility that accessory lymphatic channels may permit direct deposition of tumor cells in the mediastinal lymph nodes has not been eliminated.[2]

Pulmonary involvement seems to originate from lumbar lymph node metastases either by thoracic duct and subclavian vein, or by contiguous lymphatic extension to the hilar region and into the pulmonary parenchyma. Both mechanisms probably play a part. It is also suggested that most metastases to the liver and distant sites originate from lumbar disease.[14] A distinctly different pattern of spread with a high incidence of unpredictable hematogenous metastases and the tendency toward mediastinal skip rarely may occur.[14]

SUMMARY

Seminoma spreads most slowly and is the most radiosensitive of the testicular malignant tumors. Increasing speed of spread and local aggressions are paralleled by increasing radioresistance.[14] The most important prognostic factors in cases of testicular tumors are histology and clinical stage; they operate independently.[15] Spread may also take place through the spermatic veins, either to the left renal vein or the right vena cava.[16] Testicular tumors may spread rapidly and result in death within six months.[16]

REFERENCES

The references noted in this article may be obtained from either the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

- Found useful in the management of vertigo* associated with diseases affecting the vestibular system.
- Can relieve nausea and vomiting often associated with vertigo.*
- Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.
- Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.
- Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective. Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

VISUAL FOCUS ON ACUTE GOUTY ARTHRITIS

Foot of patient with acute gouty arthritis as seen by conventional x-ray.

Scintiphotogram of same foot reflects inflammatory process.

The scintiphotograph on the right shows increased uptake of radiotechnetium polyphosphate in the metatarsophalangeal joint and the proximal interphalangeal joint of the great toe of a patient with acute gouty arthritis. This increased uptake probably results from increased vascularity in the affected areas.

For a more detailed description of scintiphotography, see "addendum" at right.

Postinfarction Ventricular Septal Perforation: A Case Report

JIM D. BATES, D.O., DAVID GORDON, M.D.,
LIBERATO A. IANNONE, M.D.,
STEVEN J. PHILLIPS, M.D., ROBERT ZEFF, M.D.,
JOHN ANDERSON, M.D., and
JOHN MURPHY, M.D.
Des Moines and Boone

While mortality remains high, significant improvement will often result from the surgical repair of a postinfarction ventricular septal perforation. One such case is described here.

SEPTAL INVOLVEMENT has been found to be present in approximately 65% to 70% of all myocardial infarction cases. In spite of this, free perforation of the ventricular septum is rather rare. The incidence of death following post-myocardial infarction septal perforation has been reported by various offices to be at one to two per cent of all myocardial infarctions.[1] Medical management of this condition carries an 87% mortality in the first two months following rupture.[3] Operative mortality continues to be high, in spite of recent advances in cardiovascular surgery; and has been 50% or greater in most series.[4] The two primary determinants of operative risk have been the time interval between septal rupture and operation and the residual functioning myocardium. The following is a case report describing a patient with post-infarction ventricular septal rupture treated surgically.

CASE REPORT

A 63-year-old diabetic male was admitted to another hospital with a diagnosis of acute inferior myocardial infarction. At the time of admission he was noted to have a low-pitched holosystolic murmur Grade III-IV/VI present at the apex without radiation. Blood pressure was noted, but there was no neck vein distention or cyanosis. The lung fields were clear to auscultation. The patient had been examined numerous times over the years but no mention had ever been made of a heart murmur. He denied any history of hypertension or rheumatic fever.

Despite aggressive treatment over the first two-week period with bed rest, Digitalis, and diuretics, the patient developed intractable congestive heart failure with pulmonary edema and was transferred to Mercy Hospital, Des Moines, Iowa on April 27, 1975. Physical examination at that time revealed moderate neck vein distention with a positive hepatojugular reflux. Basilar rales were present bilaterally with dullness to percussion over the lung bases. Ausculation of the heart revealed a regular rhythm with a Grade III-IV/VI coarse holosystolic murmur heard best at the lower left sternal border. The murmur did not change with respiration and no third or fourth heart sounds were audible. Examination of the abdomen revealed the liver to be palpable 4 cm below the right costal margin and there was 2+ pretibial and ankle edema. Blood pressure at that time was 116/80 with a pulse rate of 94 per minute.

A repeat electrocardiogram done at the time of transfer confirmed the previous findings of posteroinferior myocardial infarction. The chest x-ray at the time of transfer showed bilateral pleural effusion to be present with pulmonary vascular engorgement and interstitial pulmonary edema.

Despite continued aggressive medical therapy, including three thoracenteses, his condition continued to deteriorate. He developed intermittent heart block with frequent multifocal premature ventricular contractions.

Dr. Bates was a surgical resident at Des Moines General Hospital and is now a resident in thoracic surgery in Chicago. Drs. Gordon and Iannone are in the private practice of cardiology in Des Moines. Dr. Phillips is a cardiovascular surgeon in Des Moines. Drs. Anderson and Murphy practice family medicine in Boone.

On May 9, 1975, right and left heart catheterization and coronary arteriography were performed. Plaquing of the left anterior descending artery with approximately 50% occlusion was noted at the takeoff of the diagonal branch. The left main coronary was normal. These was total occlusion of the right coronary artery approximately 1 cm after its takeoff. No hiatal collateralization of the right coronary could be seen. Marked inferior wall hypokinesia was present with the anterior apical wall doing most of the contracting. The ejection fraction was 63%. The ventricular injection revealed an apical inferior ventricular septal defect with a 3:1 shunt.

On May 12, 1975, the patient was taken to surgery where the entire posterior wall of the left ventricle was noted to be pale, thin, and consistent with early scar formation in the distribution of the posterior descending branch of the right coronary artery. The area of infarction was incised and a 3 cm diameter ventricular septal defect was found in the distal third of the inferior ventricular septum. The ventriculotomy and ventricular septal defect were then closed as a unit by placing strips of felt on both sides of the posterior aspect of the defect through which Eight double-armed No. 2 Ethiflex sutures were placed in mattress fashion to invaginate the edges of the ventriculotomy into the septal defect third of the left anterior descending artery. He was then successfully weaned from cardiopulmonary bypass.

His post-operative course was essentially unremarkable and he was discharged home on the eleventh post-operative day.

DISCUSSION

Death due to post-myocardial infarction septal perforation has been reported by various authors at 1-2% of all myocardial infarctions.[2] Twenty-four per cent of these patients will die within the first 24 hours, 50% within the first week, 65% within two weeks, and approximately 85% will be dead within two months.[6] Only 7% live beyond one year.

Thrombosis of the left coronary arterial system is reported to occur at least three times as often as in the right coronary system.[7] The anterior two-thirds of the septum is supplied by the left coronary artery, the posterior one-third by the right coronary artery. It has been suggested that this dual blood supply probably accounts for the low incidence of septal perforation.[8] However, due to the increased incidence of the left coronary artery disease, it is not surprising that anterior septal perforation is more commonly seen than posterior perforation.[3]

Certain factors seem to contribute to the etiology of septal perforation following acute myocardial infarction although they are not invariably present. These are: hypertension, physical exertion, massive myocardial necrosis, advanced age[5] and anticoagulant therapy.

Mallory and his associates have shown that maximal myocardial necrosis occurs between the fourth and fourteenth day following infarction. These findings are felt to be compatible with the commonly held belief that rupture occurs one to two weeks following an acute myocardial infarction. In reality, the time of rupture can be quite variable, ranging anywhere in time from less than 24 hours up to 3 weeks following the acute insult. The average is 5 to 7 days.

A sudden deterioration in the patient's condition with development of intractable congestive failure unresponsive to intensive medical treatment, a loud harsh holosystolic murmur, and an associated precordial thrill is pathognomonic of a ventricular septal defect. The only real differential is rupture of a mitral valve papillary muscle with subsequent mitral insufficiency. The problem can be readily solved by physical findings and cardiac catheterization. The electrocardiogram cannot generally be relied upon as diagnostic of rupture.

Medical treatment of interventricular septal perforation secondary to an acute myocardial infarction has been consistently disappointing, and early death from this complication is the rule. Despite this, several cases have been reported in the literature describing survival rates ranging from 41 months by Briggs and Holt,[9] a 4½ year survival by Zucker,[10] and a 4 year, 10 month survival by Wood and Livezey.[11] The longest reported survival of a case treated medically is that of a female patient of Landale and Schlappi[12] who lived 13 years and 4 months following her myocardial infarction with septal perforation.

It has been shown that surgery has much to offer these patients—not only in terms of improved survival rate, but also improved quality of life. The results of surgery seem to be related, in part, to the timing of surgery in relation to the time of infarction. Generally speaking, the closer the time of surgery to the time of infarct, the higher the risk. It is felt preferable to support the patient medically for a variable period of time if the patient's condition permits. Sometimes the patient's hemodynamic status may be so precar-

ious that emergency surgery is felt to be somewhere between 3 weeks and 2 months following the time of infarction. There are basically three methods of surgical repair. They are:[13] closure by direct suture, inclusion of the defect in the closure of an aneurysm or closure after removal of the apex, and patch prothesis.

SUMMARY

Ventricular septal defect occurring subsequent to myocardial infarction was first described by Latham in 1845. The possibility of successful surgical repair of this lesion was first demonstrated by Cooley and his associates[14] in 1957. Important surgical considerations include the following: (1) the presence of mitral valve disease; (2) the presence of a ventricular aneurysm; (3) the degree of coronary artery disease; (4) the functional status of the residual uninfarcted myocardium; and (5) the interval of time between surgery and the acute insult.

Even though the mortality rate remains high, significant improvement can often be achieved in selected patients.

REFERENCES

The references noted in this article may be obtained either from the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

QUESTION BOX

(Continued from page 43)

been active in presidential campaigns and, heretofore, we have not involved ourself in primary races. Our involvement has been that of the U. S. and Iowa legislatures.

What brief suggestions for political participation do you have for individual Iowa physicians in this election year?

The first suggestion I would have is that every individual Iowa physician and his spouse become a member of IMPAC! But please do not let your political activities stop with this important contribution. It takes a much more personal involvement to elect the candidate of your choice and to aid his interest in your problems concerning medicine. Do what you can for specific candidates such as campaign support committee work; direct contributions to the candidate; work in campaign headquarters or with voter registration by yourself or members of your family, etc. It is IMPAC's feeling that this personal involvement with candidates is the most important part of the election process, but direct financial assistance by physicians as a group, such as is done by IMPAC, still has a decided and useful place.

Inform yourself and involve yourself in the selection and election of those who will represent you.

IOWA MEDICAL MISCELLANY

(Continued from page 41)

1976 NOMINATIONS . . . March 28 has been set as date for the 1976 IMS Nominating Committee to meet at Society Headquarters. Selection of delegates to serve on the Nominating Committee (one from each of the 12 councilor districts) is about to begin. District caucuses will occur in late February and early March.

MEET WITH NURSES . . . IMS representatives on MD-RN Liaison Committee met January 13 with their nurse counterparts to consider several topics. Part of discussion centered on nurses' intention to seek revision in their practice act in this session of the legislature.

MEDICAID PAYMENTS . . . Title XIX payments to Iowa physicians for FY 1974 appeared in the press in late December. $8 million was paid to MDs with the average amount per individual doctor pegged at about $2,400. Highest amount reported to have been paid a single MD was $56,312 to a non-IMS member in general practice.

SAFE TRANSPORTATION . . . IMS Committee on Safe Transportation met January 15 with officials of the Iowa Department of Transportation. Part of the discussion concerned legislation to allow indication on the driver's license of a desire to donate a body organ. Society's Committee on Organ Transplantation has supported this idea.

Editorials

M. E. ALBERTS, M.D., Scientific Editor

AN EXTRA DAY

February is the shortest month, but this year it does have an extra day. What should we do with that extra 24 hours? Some sort of special celebration should be in order. A day has been set aside already for hearts and flowers, so we do not need another Valentine's Day. A day has been set aside to honor the birth of Lincoln, and another to commemorate the birth of Washington. There are no special deadline days in February for another one of those disgusting government report forms. What then can we do with the 29th in a special way? My birthday isn't until March, so that is out of the question. My wedding anniversary (the 31st) was on Christmas Day, so that is taken care of for another year.

Hey, I have it! Though it occurs but once every four years, that little bit of glory might be enjoyed by a group to which I belong. Let's celebrate the 29th as Medical Journal Editor's Day. Lord knows it is tough some months to get an editorial or two written, and I've really dug deep for this one. Remember us on the 29th, and we will keep trying for better editorials for another four years.—M.E.A.

DOCTOR-NURSE COMMUNICATION

The intensive-care nurse holds a unique position. She provides much aid and support to the physician in his dealings with the family of a terminally-ill patient. This relationship is especially important when the patient appears to be alive only by virtue of machines of various types —resuscitators, intravenous fluid pumps, and other pieces of sophisticated gadgetry that draw out the process of dying long after the electroencephalogram tracing is flat. The physician's contact with the patient loses its personal nature because the patient can neither respond nor interact; the physician must relate entirely with the family, and often in a fleeting way. The nurse is left with the patient and the family, to provide the necessary nursing care and to serve as confidant and counselor.

Questions often go unanswered. The nurse may need more and better communication with the physician so both can understand the case and the personalities involved. The physician is subjected to the futility syndrome. The nurse may feel inadequate to handle her difficult task. Either or both may feel something else could or should be done. I wonder if physicians realize the emotional impact upon the nurse who must live with and share the grief of the family whose loved-one is hooked to all that machinery. Does the nurse realize the pain in a physician's heart when he knows there is nothing more he can do for a dying beautiful child?

Actually, the physician has the easiest part of the entire scenario of the last act in the play of life. He places the nurse in the most active role. He sets the stage, moves a few props here and there, rewrites the lines to fit the scene and then steps off-stage to await the results. The nurse remains center-stage to deal with the needs of the patient and his family. Often the nurse must cry out silently in her heart for more emotional support from the physician. How crushed she must feel when the physician seems cold to the entire situation.

(Please turn to page 62)

Testing in Humans: Who, Where & When.

e weight of ethical opinion:

Few would disagree that the effective- and safety of any therapeutic agent evice must be determined through ical research.

But now the *practice* of clinical re- ch is under appraisal by Congress, the s and the general public. Who shall inister it? On whom are the products e tested? Under what circumstances? t how shall results be evaluated and zed?

The Pharmaceutical Manufacturers ociation represents firms that are sig- antly engaged in the discovery and elopment of new medicines, medical ces and diagnostic products. Clinical arch is essential to their efforts. Con- ently, PMA formulated positions ch it submitted on July 11, 1975, to Subcommittee on Health of the Sen- Labor and Public Welfare Committee, s official policy recommendations. e are the essentials of PMA's current king in this vital area.

1. PMA supports the mandate and sion of the National Commission for Protection of Human Subjects of nedical and Behavioral Research and rs to establish a special committee posed of experts of appropriate iplines familiar with the industry's arch methodology to volunteer its ice to the Commission.

2. PMA supports the formation of an pendent, expert, broadly based and resentative panel to assess the current e of drug innovation and the impact n it of existing laws, regulations and edures.

3. When FDA proposes regulations, ould prepare and publish in the *Fed- Register* a detailed statement assess- the impact of those regulations on g and device innovation.

4. PMA proposes that an appropri- y qualified medical organization be ouraged to undertake a comprehen- study of the optimum roles and onsibilities of the sponsor and physi- when company-sponsored clinical arch is performed by independent ical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

EDITORIALS

(Continued from page 58)

I do not wish these comments to be misconstrued. I mean not that nurses and physicians should cry upon each others' shoulders. We should, however, communicate our feelings. We should not isolate the nurse from discussion of the matters at hand. If there is to be discussion with the family regarding progress or lack of progress, or consideration of disconnecting all the machinery because of the futility of their use, then the nurse should be there. She has a right to know the physician's thoughts and feelings, and at the proper time the physician should know her feelings. There can be mutual support during such trying times.

Death is a complex phenomenon. To let a patient die is not related to killing. When the prospects of life as we know them have reached an irreversible state, the continuation of futile acts no longer serve the concepts of responsibility. The nurse in the intensive-care unit, directly caring for the patient, is a vital character in a tense drama. Communication with her is paramount. Do not leave her speechless, standing alone in the center of the stage. She needs you, doctor; you need her; the patient's family needs both of you. —M.E.A.

A COMPREHENSIVE PROGRAM IN IOWA FOR PATIENTS WITH EPILEPSY

(Continued from page 50)

Clinical research directed toward improvement in diagnosis and treatment of epilepsy will continue in the Department of Neurology at the University Hospitals in Iowa City to the maximum allowed by available time and financial support.

The College of Medicine of the University of Iowa will continue with educational efforts for professional, paraprofessional and non-professional personnel who must provide care for the epileptic. These efforts will emphasize the latest advances in all areas. Training of future professionals and paraprofessionals in the field of epilepsy will continue to be emphasized. Increasing lay education may be accomplished by various lay groups—such as local chapters of the Epilepsy Foundation of America. These educational accomplishments are of basic importance in establishing and maintaining the best quality of life possible for patients with epilepsy.

Establishment of a comprehensive epilepsy program would provide resources important to the coordination of many of the available services necessary for a better life for the epileptic. Research efforts directed toward improved diagnosis, treatment and psychosocial problems would be facilitated by the establishment of such a program.

ACKNOWLEDGMENTS

This feasibility study was accomplished only with the help of many individuals and organizations who share the common goals of improved care and quality of life for patients with epilepsy.

CONTINUING EDUCATION COURSES & CONFERENCES

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

March 3	Ophthalmology Clinical Conference
March 3	Diet Therapy U.S.A.
March 10	Managing Common Skin Problems
March 11	Vision Workshop for the Family Physician
March 29-April 1	Cardiology Today
April 5-9	Intensive Course in Pediatric Nutrition
April 6-8	Iowa Medical Society Scientific Meeting
April 7	Ophthalmology Clinical Conference
April 10-11	Midwest Residents in Anesthesiology
April 20-24	Course and Workshop on Echo-Ophthalmography
April 24-25	Eye Enucleation Course
April 29-30	Recent Advances in Reproductive Immunology

Medical Assistants

by TENORA MEYER, CMA

20TH ANNIVERSARY AAMA

AAMA is celebrating its 20th birthday this year. October 1956 is a uniquely significant time in AAMA's history for it was then that the charter meeting was held in Milwaukee, Wisconsin. Each component chapter is urged to plan its October 1976 meeting as a 20th anniversary celebration of the founding of the national organization.

In October 1956 representatives from six Iowa cities met in Des Moines to discuss the organization of a state association. Seventy-seven medical assistants from 15 states met in Kansas City, Kansas, to discuss the formation of a national association. Present at these meetings were doctors representing county and state medical societies and the American Medical Association. The medical assistants present were interested in their own need for professional improvement and in benefits they might derive from educational facilities offered by a national organization.

In November 1956, the House of Delegates of the American Medical Association passed a resolution commending the objectives of AAMA.

From a nucleus of 77 members from 15 states, AAMA has grown to more than 16,000 members on the national level, with a national office in Chicago, Illinois.

The AAMA, on 3 levels of membership—local, state and national—extends an invitation to membership to all medical assistants who are regularly employed by a physician. Membership at large is offered to those residing in a section of the state or country where there is no chapter of this association. If a chapter is subsequently formed in such a locality, members will affiliate with the local chapter. Iowa presently has chapters at Des Moines, Davenport, Waterloo, Mason City, Cedar Rapids and Sioux City.

ESSAY CONTEST

The AAMA 20th Anniversary Committee is sponsoring an essay contest in connection with this big event. The member who submits the best essay on "How to Show Love to Patients" will receive $100, a prize donated by Maxine Williams, CMA-A, first president of AAMA. Along with this event, it is stated that, "It's easy to love all patients when everything is 'coming up roses,' as the saying goes, in our professional and personal lives. But does that love go on radiating during each working day, even those days when we're under tremendous pressure and strain? The ability to show kindness and compassion and to have empathy for all patients is essential for success as a medical assistant. This particular aspect of our profession is so important that it has been chosen as the topic for this special activity."

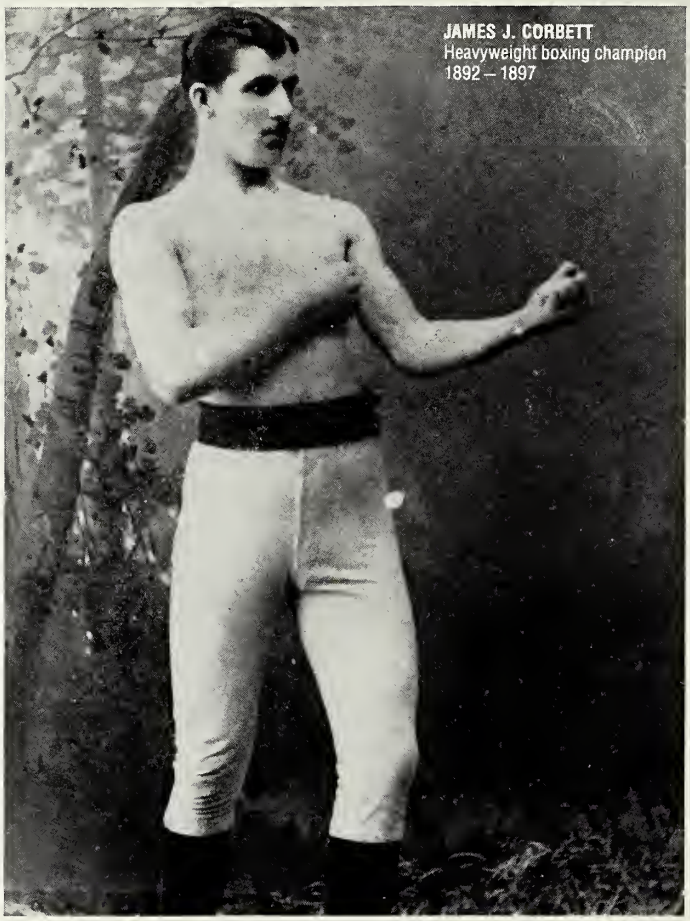
A selected number of finalists—to be determined by the total number of entries received—will be asked to present their essays verbally at the 1976 national convention in Chicago. The length of the article should be planned to accommodate a five-minute presentation before an audience of peers.

The following guidelines for entering the contest have been established:

1. Topic: "How to Show Love to Patients."
2. Entry must be typewritten, double-spaced, with at least a one-inch margin on all sides. Only

(Please turn to page 67)

Famous Fighters



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Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin* is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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About IOWA Physicians

Dr. Herbert Sohm, Des Moines, was recently presented a golden anniversary citation by Creighton University for his 50 years of service to mankind and loyalty to the University. Dr. Sohm is a 1925 graduate of Creighton Medical School. . . . **Dr. Joseph Spearing,** Harlan, will represent Shelby County on the recently reorganized board of directors of the Health Planning Council of the Midlands. . . . **Dr. Dave Sidney,** who recently completed a surgery residency at U. of I. College of Medicine, has joined **Dr. C. S. Tam** in Washington. Dr. Sidney received the M.D. degree at University of Minnesota Medical School. Prior to entering the U. of I. College of Medicine, Dr. Sidney served a two-year residency at Harvard Medical School and Peter Bent Brigham Hospital in Boston, Mass. . . . **Dr. Dale Harding,** Eagle Grove, presented a lecture at Ellsworth Community College in Iowa Falls on "Prudent Heart Living." . . . **Dr. J. R. Gambill,** superintendent of Mental Health Institute in Clarinda, has resigned from this position but will remain as clinical director. Dr. Gambill has been superintendent of the Institute since 1967. In recent years, Dr. Gambill has assumed the duties of both the clinical directorship and superintendency.

Dr. W. A. Anneberg, Carroll, was honored recently by the Carroll Rotary Club for his nearly 52 years of service to the Club, the Rotary Foundation and the community. The distinguished Paul Harris Fellow Award was presented to Dr. Anneberg along with a plaque and congratulatory letter from General Secretary Harry A. Stewart of Rotary International. . . . **Dr. Najed Chaarani,** former Shenandoah physician, is practicing thoracic and cardiovascular surgery in Council Bluffs. Dr. Chaarani is currently completing a series of chest surgery refresher courses in several midwest medical centers. . . . **Dr. Roland E. Erikson,** Davenport, has joined the staff at the Great River Mental Health Center. Dr. Erikson received the M.D. degree at University of Illinois School of Medicine in Chicago and completed his postgraduate work at the University of Minnesota and Langley Porter Institute at the University of California. . . . **Dr. Amer Haidar** recently joined the staff at the Clinton County Mental Health Center. A native of strife-torn Beirut, Lebanon, Dr. Haidar was forced to leave his homeland. His psychiatric residency was completed at U. of I. College of Medicine.

Dr. Gerald M. Paluska has joined the Gilfillan Clinic in Bloomfield in the practice of surgery. Dr. Paluska received the M.D. degree at U. of I. College of Medicine in 1970; interned at University of Pennsylvania in Philadelphia and completed surgery residency at U. of I. College of Medicine. . . . **Dr. Randall R. Maharry** recently began the private practice of dermatology in Des Moines. Dr. Maharry received the M.D. degree at U. of I. College of Medicine and interned at Los Angeles County Hospital in Los Angeles. Prior to completion of his residency in dermatology at University Hospitals, Dr. Maharry was an emergency room physician at St. Luke's Methodist Hospital in Cedar Rapids. . . . **Dr. Richard M. Caplan,** associate dean for Continuing Medical Education at U. of I. College of Medicine, chaired a meeting of the subcouncil for education and communication at annual meeting of American Academy of Dermatology in San Francisco. Dr. Caplan also lectured on "Educating Your Patients" and "Education in Dermatology." . . . **Dr. Alford Karayusuf,** newly-appointed medical director of Mental Health Center of North Iowa spoke at the October meeting of Wright County Medical Society. **Dr. John Bao Dwong,** Vietnamese physician now living in Dows, was a guest of the Society.

Dr. W. H. Verduyn, Reinbeck, and **Dr. Ralph L. Wicks,** Boone, discussed physician recruitment at recent refresher course for family practitioners at U. of I. College of Medicine. . . . **Dr. R. L. Baltzell** closed his medical practice in Anthon on December 20, and in January joined the Ranch Viejo Medical Clinic near Brownsville, Texas, a recently built multi-million dollar medical complex. Dr. Baltzell had practiced medicine in Anthon since 1959. . . . **Dr. Percy G. Harris,** Cedar Rapids family practitioner since 1958, has been elected president of the medical staff at St. Luke's Methodist Hospital. CR physicians serving with Dr. Harris are—**Dr. Dale D. Morgan,** president-elect; **Dr. John Huston, Jr.,** vice president, and **Dr. Robert L. Swaney,** secretary-treasurer. . . . **Dr. William D. Blohm,** Carroll, was recently presented a plaque for his six years of service on the Carroll Community School Board. . . . At annual meeting of Marshall County Medical Society, **Dr. Philip R. McFadden** was elected president; **Dr. Gary A. Draper,** vice president; and **Dr. Charles Bendixen,** secretary. All are Marshalltown physicians. . . . **Dr. E. E. Gamet,** Lamoni, has been re-elected president of Iowa State Board of Health; **Dr. Paul M. Seebohm,** executive associate dean at U. of I. College of Medicine, is vice president. . . . **Dr. M. G. Parks,** Centerville, has been named to Board of Directors of St. Joseph's Mercy Hospital. Dr. Parks has practiced medicine in Centerville since 1966.

Dr. and Mrs. F. B. Leffert, Centerville, recently donated an X-ray machine to the Appanoose County Historical Society which has been in use in Centerville for approximately 75 years. The X-ray machine will form the nucleus for a medical center at the historical museum located in the former Appanoose County jail. The Lefferts also donated an instrument cabinet as well as medical periodicals and books.

DEATHS

Dr. L. E. Jensen, 82, longtime Audubon physician, died December 7 at the Audubon County Memorial Hospital. Dr. Jensen received the M.D. degree at U. of I. College of Medicine and began his medical practice in Audubon in 1922. In 1969 he received the Audubon Chamber of Commerce annual Community Service Award for delivering

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an estimated 5,000 babies in the area. He was a life member of the Iowa Medical Society.

Dr. Otis P. Morganthaler, 85, former Templeton physician, died December 7 in Tarpon Springs, Florida. Dr. Morganthaler practiced medicine in Templeton for 30 years. He received the M.D. degree at Creighton University School of Medicine and interned at St. Joseph Hospital in Omaha. He was a past president and life member of the Iowa Medical Society.

Dr. Solomon Greenhill, 70, Des Moines, died December 8 of a heart ailment while attending a conference of the American Academy of Dermatology in San Francisco, California. Dr. Greenhill received the M.D. degree at University of Michigan Medical School. He was a member of American Academy of Dermatology and diplomate of the National Board of Dermatology.

Dr. Harold R. Peasley, 82, Des Moines, died December 24 at University Hospitals in Iowa City. Dr. Peasley received the M.D. degree at U. of I. College of Medicine in 1920 and practiced medicine in the Des Moines area for over 50 years. He retired in 1972. He served as chief of staff at Mercy Hospital and was on the staff at Iowa Lutheran, Iowa Methodist Medical Center and VA Hospital.

MEDICAL ASSISTANTS

(Continued from page 63)

one side of each sheet of paper may be utilized, and the length should not exceed five minutes when read aloud.

3. Entrant's name, address (including zip code), and telephone number (including area code) should be placed in upper righthand corner of each subsequent page. Each page after the first should be numbered consecutively, the page number to appear directly under the entrant's name.

4. Two copies of each entry are to be submitted. The original should be mailed to the AAMA Executive Office, One East Wacker Drive, Suite 1510, Chicago, Illinois 60601. A carbon copy should be mailed to 20th Anniversary Events Committee Member, Mrs. Teve Williams, 537 Sanford Drive, Fort Myers, Florida 33901.

5. Entry must be postmarked no later than July 1, 1976.

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VA PAY IS HIGHER than ever before since passage of physician bonus bill. Psychiatrists, or physicians with training and interest in psychiatry, are needed in this modern medical and surgical hospital with over 600 psychiatric patients presenting the full range of treatment needs. Expanding affiliation with the University of Illinois, Champaign-Urbana, will provide opportunity for professional training and development, plus possible staff teaching assignments. The 40-hour a week work schedule and the 30-day annual vacation will also provide ample time for personal and family activities. Fringe benefits include sick leave, health and life insurance, retirement, malpractice coverage, housing and free golf course and tennis courts on station grounds. Our city of 42,000 allows a relaxing way of life atmosphere, but is within easy reach of Indianapolis and Chicago. Call or write Dr. Kannapel, VA Hospital, 1900 E. Main St., Danville, IL 61832, 217-442-8000.

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FOR SALE—WELL-ESTABLISHED DES MOINES OFFICE FOR PRACTICE OF DERMATOLOGY—Waiting room, consulting room, four treatment rooms, laboratory and office. Excellent opportunity for physician. Contact Mrs. Solomon Greenhill, 3663 Grand Avenue, Des Moines, Iowa 50312.

FAMILY PRACTITIONER seeks **FAMILY PRACTITIONER** to cover his practice for one year as soon as available. Salary $40,000 yearly. Week-end and vacation coverage available. Practice located in northeast Iowa. Address your inquiries to Rural Family Practice Clinic, P.C. W. H. Verduyn, M.D., 514 Main, Reinbeck, Iowa 50669.

PHYSICIAN—SOUTH DAKOTA—Dept. of Health, Medical Director of maternal and child health and crippled children program. Graduate of approved school of medicine with pediatric and neonatal training. MPH desirable. Must be licensed to practice medicine in S.D. or eligible for license within six months. Appointment to new four-year medical faculty may be considered. Salary negotiable. Apply to: Secretary of Health, Joe Foss Bldg., Pierre, South Dakota 57501.

PHYSICIAN—SOUTH DAKOTA—Dept. of Health, Chief of Medical Services. Covering activities in communicable disease, laboratory services, public health nursing, emergency medical services and other related services. Graduate of an approved school of medicine. Must be licensed to practice medicine in S.D. or eligible for license within six months. Appointment to new four-year medical faculty may be considered. Salary negotiable. Apply to: Secretary of Health, Joe Foss Bldg., Pierre, South Dakota 57501.

EMERGENCY DEPARTMENT STAFF PHYSICIAN—455-bed hospital in suburban Omaha. One of five M.D.'s. New 14,000 sq. ft. department approved with construction to begin in Spring. Visits per month: 2500-3000. Hospital based specialists: neonatology, pulmonary disease, cardiology, anesthesia, pathology and radiology. Remuneration: $40-60,000 plus good fringes, depending upon experience. Experience in E.D. desired. Write or call J. R. McCaslin, M.D., Director, Archbishop Bergan Mercy Hospital, Omaha, Nebraska 68124. 402/398-6031.

PSYCHIATRIC RESIDENCY—Vacancies for positions for those who have a regular Iowa license or can obtain one by reciprocity or via the FLEX. Prepare for career in private practice, community clinics or hospital based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, Children's Unit, Adolescent Unit. Neurology affiliation with University of Iowa. The stipends are: 1st year, $20,280; 2nd year, $21,294; 3rd year, $22,360. Intensity and diversity of training program appreciated best by personal visit. Superintendent, Mental Health Institute, Cherokee, Iowa 51012. Equal Opportunity Employer. Call Collect 712/225-2594.

UROLOGIST NEEDED TO JOIN one older urologist in 36-man multispecialty group. New building adjacent to largest hospital in city. Excellent recreational area. City of 65,000. Salary first year. Partnership with income based on productivity. Call collect or write: Robert A. Pfaff, M.D., 1000 Langworthy, Dubuque, Iowa 52001. 319/557-6278.

PHYSICIAN ASSISTANT IS SEEKING a position with a Primary Care Physician. I wish to settle in a small Iowa town. Graduating from University of Iowa College of Medicine P.A. Program in May, 1976. For information contact David Askelson, 651 Hawkeye Drive, Iowa City, Iowa 52240. Phone 319/351-3094.

WANTED—ANESTHESIOLOGIST with interest in family practice, **GENERAL INTERNIST** and **FAMILY PRACTITIONER** to join 11-man professional corporation. Lucrative financial package, excellent fringes, great recreational facilities and a good place to raise a family. Hospital is seven years old, progressive and expanding. Contact M. Brentnall, CPA, Creston Medical Clinic, P. C., 526 New York Avenue, Creston, Iowa 50801.

STUDENT HEALTH SERVICE PHYSICIAN WANTED—Sports medicine interest desirable. Excellent University with attractive campus and performing arts center. Excellent fringe benefits. Salary negotiable. Contact Director, Loren L. Augustyn, M.D., Student Health Service, Iowa State University, Ames, Iowa 50010. Phone 515/294-5801.

WEST DES MOINES CLINIC—Architect designed medical clinic on ground floor in new office building. Includes large waiting and reception area, clerical office, 5 examining rooms, X-ray room and lab, electrocardiogram room, lounge, storage rooms, doctor's private offices. Ample off street parking—up to 55 cars in a park like one acre setting. **IMMEDIATE OCCUPANCY AVAILABLE.** Please contact Roy McKay, Grodt & McKay Realty, West Des Moines, Iowa 50265. Phone 274-3511 days or 225-7919 eves.

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respond to one

According to her major
ptoms, she is a psychoneu-
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sound like depression.
h is because her problem,
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provide relief for both—as
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There are other advan-
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vement is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

eillance because of their predisposi-
to habituation and dependence. In
nancy, lactation or women of child-
ing age, weigh potential benefit
nst possible hazard.

autions: If combined with other psy-
opics or anticonvulsants, consider
fully pharmacology of agents em-
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otics, barbiturates, MAO inhibitors
other antidepressants may potentiate
ction. Usual precautions indicated in
ents severely depressed, or with latent
ression, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

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Division of Hoffmann-La Roche Inc.
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President's Page

The business, purpose and object of this corporation or society shall be to promote, extend, elevate and advance medical science and medical knowledge.

This excerpt from the Society's Articles of Incorporation is pertinent on the eve of our 1976 Annual Scientific Session. We will convene in Iowa City at noon on Tuesday, April 6, and conclude on April 8. An outline of the program is provided in this issue for your consideration.

May I express profound appreciation to the Program Committee for doing an excellent job of arranging a most interesting educational meeting. A topflight array of speakers from the University and elsewhere will cover topics of interest all across the medical spectrum.

A reception for physicians and their spouses is planned Tuesday, April 6, at the Highlander Inn. It will be sponsored by the University of Iowa Alumni Association and the College of Medicine. The annual banquet will be Wednesday evening, also at the Highlander, with entertainment by the Old Gold Singers.

Please join us in Iowa City for this worthwhile meeting. I look forward to seeing many of you.

Sincerely,

V. L. Schlaser MD

V. L. Schlaser, President

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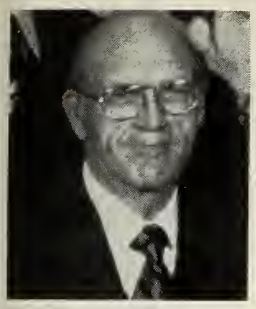

The Question Box

by LAWRENCE O. ELY, M.D.

Dr. Ely is chairman of the 1976 Iowa Medical Society Program Committee. He is a surgeon in private practice in Des Moines. He and his fellow committee members have developed the 1976 Scientific Program which is described elsewhere in this issue.

Do you want to invite IMS member physicians to Iowa City April 6, 7 and 8?

Yes, by all means. The Iowa Medical Society is holding its annual Scientific Session in Iowa City on April 6, 7 and 8. The sessions are being held at both the Highlander Inn and the University of Iowa College of Medicine. Registration begins at the Highlander at 11 a.m., Tuesday, April 6. The opening sessions are at the same place beginning at 1 p.m. An interesting meeting has been planned for all Iowa physicians.

How would you characterize the 1976 Scientific Session—something for everybody?

We have attempted to appeal to a broad range of interest and at the same time make available a good amount of practical information. Sessions will cover prescribing practices, therapeutic blood levels, out-dated tests, the sexually assaulted person, myocardial attacks and surgery on the heart, PVC's, thermograms, xerograms, suture techniques, lung disease, anuria, oral contraceptives, oral hypoglycemic agents, rheumatology, chemotherapy, fiberoptics, adolescent medicine, and Iowa's Health Systems Agency (HSA). A diversified session on "What's New in Medicine" is planned which should be helpful.

Why should an Iowa physician consider attendance at this session when there's a lot of CME to choose from?

It's convenient, concise, timely and interesting. What's more, you will meet old friends and see the University's new physical facilities.

What criteria are used in developing a program of this type?

The program must appeal to all doctors in the state. It must be clinically applicable to the practices of these physicians. This is the basic criterion which is considered throughout the year as planning goes forward. It's certainly our hope that a goodly number of Society members will find the program sufficiently appealing to come to Iowa City.

▲ **Milwaukee Psychiatric Hospital** { Intensive, dynamic psychotherapy for adults and adolescents, individually planned activity therapy.

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Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

TRAINING OF FAMILY PRACTITIONERS IN HIGH GEAR

IOWA'S STEPPED-UP PROGRAM to train family physicians began just a few years ago. And the brief ensuing period has seen substantial progress. Actually, the full-fledged Statewide System for Family Practice Residency Training was authorized in 1973 by the 65th Iowa General Assembly.

Twelve FP residents were in training in three approved centers prior to 1973. This included the residency program of the Department of Family Practice at the University of Iowa. Since 1973 there's been steady, if not dramatic, growth (a) in number of programs, (b) in medical student interest in family practice, and (c) in number of residents in training.

Now there are seven active training programs within the System. Each has a full-time director and each is accredited. An eighth program is set to begin operations in Waterloo this year. And a ninth program, one affiliated with Des Moines General Hospital, has been proposed. The System is expected to hold at this level until all reach capacity.

Operative programs are in Iowa City, Cedar Rapids, Davenport, Mason City, Sioux City and Des Moines (2).

The interest among medical graduates in family practice as a career continues to grow. In excess of 700 inquiries have been received by the directors of Iowa's family practice residency programs. They have had more than 170 applications for the 46 first-year positions to be available in July, 1976. This is up from 613 inquiries and 134 applications at the same time last year.

Among the 1975 graduates of the University of Iowa College of Medicine, 36 students or 25% of the class entered family practice residencies. Approximately half sought training in Iowa and half in programs outside the state. These statistics show the interest in family practice among freshmen is being maintained through medical school.

As mentioned, the Statewide FP System has the capacity to accommodate 46 residents in each of the three years of training. All of the operating programs have residents enrolled except Sioux City. Sioux City was accredited in October, 1975, and will have residents for the first time in 1976. And with the development of Waterloo, the system will have a capacity of at least 50 residents per year, for a 3-year total of 150.

Enrollment in the Iowa family practice residency programs has increased steadily the past five years. In 1970 there were no FP residents in training in Iowa. Five years later there are 104. Iowa has kept pace with national growth in this area; countrywide participation has increased from 165 in 1970-71 to 3,700 in 1975-76.

The first class of residents of a significant size will graduate from the System this July. Twenty-three residents from three programs—University of Iowa, Cedar Rapids and Des Moines (Broadlawns)—will complete their work. It is projected this number will increase to 39 next year and 42 in 1978.

Competition for the services of these family practitioners is keen. The FP program directors have received inquiries from more than 100 communities interested in attracting a physician. Several placement mechanisms, including the long-standing program of the Iowa Medical Society, are available to both communities and physicians to help in the location process.

Funding for the broad program has come from multiple sources and has increased obviously in relation to the overall growth. The first year (1973-74) cost was $1.2 million, this increased to $2.7 million in 1974-75, and to $3.9 million in the current budget. A budget in excess of $5 million has been proposed for 1976-77. Of the various components which comprise the total budget, community hospital support is largest in amount. Other funds come from a state appropriation, from federal grants and from patient care revenue.

It all looks good for the future. Interest of medical students in family practice is holding strong, as it is with the other primary care specialties. These developments combined with the expanding training opportunities should soon have a significant effect on correcting both the shortage and distribution of doctors in Iowa.

IN THE PUBLIC INTEREST

SCIENTIFIC ARTICLES

Neonatal Necrotizing Enterocolitis: Current Experience at Raymond Blank Memorial Hospital for Children

LUKE TAN, M.D., Ph.D., and
B. CHANDRAMOULI, M.D.
Des Moines

Seven cases of necrotizing enterocolitis are reported. The incidence was of a clustered nature and affected mainly stressed premature neonates. Observations on these cases are correlated with the current understanding of the disease.

NECROTIZING ENTEROCOLITIS affects mainly stressed neonates and carries a high mortality.[1] It has been reported with increasing frequency in modernly equipped neonatal units that salvage a growing number of premature infants suffering from respiratory distress syndrome.[2] The disease is characterized by abdominal distention, failure to take feedings, vomiting, ileus and hematochezia. Abdominal roentgenograms classically reveal pneumatosis intestinalis suggesting air dissecting through the walls of the gut. Surgical or postmortem pathologic findings present extensive necrosis of the small and large intestines. The etiologic factors have been variously attributed to congenital anomalies of the bowel wall,[3] localized Shwartzman reaction,[4] pyogenic bacterial infection,[5] purulent amnionitis,[6] endotoxin and lysozyme factors,[7] perinatal hypoxia,[8] catheterization of the umbilical vessels,[9] diminished lysozyme content in the intestines of infants not on breast milk,[10] and a diving reflex-like phenomenon or low flow syndrome.[1] Presumably severe hypoxic episodes in these neonates with hyaline membrane disease is associated with hypotension and shock-like clinical picture. In order to maintain blood supply to the vital organs, there is adjustment in the volume flow to various systems in the body, with resultant marked decrease in blood flow to the gastrointestinal system. This induces hypoxia to the gut by decreased perfusion of tissues. The damage done to the gastrointestinal mucosa may become a nidus for bacterial entry and/or show necrosis. The multitude of causes incriminated testifies mutely to an unclarified pathogenesis. The methods of management consequently remain largely unsatisfactory.

Dr. Tan is a resident in pediatrics and Dr. Chandramouli is director, Neonatal Intensive Care Unit, at the Raymond Blank Hospital for Children, Iowa Methodist Medical Center, Des Moines, Iowa, and Assistant Professor of Pediatrics, University of Iowa, Iowa City.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF MARCH, 1976.

TABLE I

BIODATA, APGAR SCORES, AND AGE OF ONSET OF INITIAL MANIFESTATIONS OF SEVEN NEONATES WITH NECROTIZING ENTEROCOLITIS

Patients	Sex	Gestational Weeks	Birth Weight (grams)	Apgar 1"	Apgar 5"	Age of onset of N.N.E. (days)
J. R. "B"	M	34	2113	2	8	3
B. G. "A"	M	35	1518			1
A. T. "A"	M	32	1007	1	5	6
A. T. "B"	F	32	1347	7	8	20
T. L. "A"* ...	F	31	1191			11 31†
C. C.	M	30	1304			6
B. E.*	M	39	3430	4	5	7
Average	M/F = 5/2	33	1844	3	7	8

* Survivors.
† Second episode.

The present study analyzes the cases admitted to the neonatal intensive care unit at Raymond Blank Memorial Hospital for Children between November, 1972, and December, 1974, and correlates the findings with the current understanding of neonatal enterocolitis.

MATERIALS AND METHODS

There were 991 admissions to the neonatal intensive care unit at Raymond Blank Memorial Hospital for Children from November, 1972, to December, 1974. One hundred and eighty-four of these were premature infants with respiratory distress syndrome. During this period, 7 cases of necrotizing enterocolitis were identified. Except one, all affected the premature infants with respiratory distress syndrome. These cases constitute 0.7% of all admissions to the unit and 3.3% of all premature babies with respiratory distress syndrome.

All 7 cases were investigated along 5 general areas:

1. *Biodata:* Sex, gestational age, types of birth (single or multiple), birth weight.

2. *Etiologic circumstances:* Age of onset of initial manifestations, Apgar scores, presence of perinatal hypoxia, umbilical artery catheterization, use of feeding tubes and formulas containing greater than 20 calories per ounce.

3. *Diagnostic aids:* Abdominal distention, feeding intolerance, bilious vomiting, hematochezia, abdominal x-ray findings, results of various cultures, pathological findings.

4. *Management:* Oral and intravenous antibiotics, cessation of feedings by gastrointestinal route, parenteral feeding, correction of acidosis and electrolyte imbalance, surgery, breast milk.

5. *Outcome:* Recovery, complications, mortality.

RESULTS

A. *Biodata and Background Pathology*

The present study included 7 neonates. One was admitted in 1972, none in 1973, 6 in 1974. There were 5 males and 2 females. Five of the 7 were products of twin pregnancies, 2 of the 5 twins were brother and sister (A.T. "A" and "B"). Their average gestational age was 33 weeks, their birth weight averaged 1844 gm. Except for one (B.E.) all were premature infants. Apgar scores were available in 4 patients, averaging 3 and 7 at 1 and 5 minutes of age respectively. The onset of the initial manifestations took place between 1 and 20 days of age. The average age of onset was on the eighth day. (Table I)

All 7 patients suffered some degree of hypoxia at birth or shortly after, requiring supportive measures in the form of oxygen administration, continuous positive airway pressure ventilation or mechanical respiratory support. The episodes in which their partial pressure of arterial oxygen fell below 50 mm Hg were sporadic, and were generally corrected promptly by continuous monitoring and manipulation of supportive measures. All 7 patients had umbilical artery catheterization. The catheter was still present in 5 patients when symptoms of vomiting or abdominal distention began. It had been removed in the other 2 patients 3 and 8 days prior to the onset of symptoms, after 2 and 3 days of placement in the abdominal aorta. The tip of the catheter was maintained at or above the level of the diaphragm except in 1 patient where it was placed at the level between L_2 and L_3. Six of the 7 patients were products of preterm pregnancies of less than 35 weeks gestation, with 5 of them weighing less than 1600 gm. Feeding was given through nasogastric tubes in 2 patients, and through nasojejunal tubes in 4. Of these 6 patients, 5 had received formulas containing greater than 20 calories per ounce 1 to 3 days prior to the onset of clinical signs of necrotizing enterocolitis. (Table II)

B. *Clinical Findings*

Persistent and progressive abdominal distention was observed in all patients from 1 to 5 days

TABLE II

FACTORS ASSOCIATED WITH 7 CASES OF NECROTIZING ENTEROCOLITIS

Factors	*No. of Cases*
Hypoxia	7
Umbilical catheter	7
Prematurity	6
Hyperosmolar formula	5
Nasojejunal feeding	4
Nasogastric feeding	2

prior to the final catastrophe of perforation, septicemia or death. Delayed gastric emptying evidenced by increased residual formula in the stomach, spitting and bilious vomiting preceded the abdominal distention in 5 of the 7 patients. Hematochezia was seen in 3 patients either during or after the development of abdominal distention. Abdominal roentgenograms were available in 6 patients, all showed bowel distention, thickening of the walls and bowel loop separation. Pneumoperitoneum was present in 1 and pneumatosis intestinalis in another. Autopsy or surgical pathology findings were available for 5 patients. All were confirmed to have necrotizing enterocolitis involving the ileum and colon. Four of the 5 cases also revealed either gross or microscopic perforation. The perforation involved the ascending colon in 2 cases, the transverse colon in 1 case and the sigmoid colon in another. In addition, patent ductus arteriosus was present in 2 cases. Atelectasis, intraventricular hemorrhage, hyaline membrane disease also involved 1 case each. The sixth case in which autopsy was refused had roentgenologic sign of pneumatosis intestinalis in addition to the clinical course of bilious vomiting, abdominal distention and hematochezia. The seventh case had two separate episodes of abdominal distention, bilious vomiting with hematochezia. She recovered but developed colonic stricture 8 weeks later and underwent surgery elsewhere. (Table III)

TABLE III

CLINICAL FINDINGS IN NECROTIZING ENTEROCOLITIS

A. Physical Signs (7 cases)		
Abdominal distention		7
Spitting, vomiting and delayed gastric emptying		5
Hematochezia		3
B. Roentgenologic signs (6 cases)		
Bowel loop separation, bowel distention, gut wall thickening		6
Pneumoperitoneum		1
Pneumatosis intestinalis		1
C. Autopsy/necropsy findings (5 cases)		
Necrosis in ileum and colon		5
Perforation		4
Ascending colon	2	
Sigmoid colon	1	
Transverse colon	1	
Additional pathologic findings		5
Patent ductus arteriosus	2	
Atelectasis	1	
Intraventricular hemorrhage	1	
Hyaline membrane disease	1	

TABLE IV

RESULTS OF BLOOD AND GASTRIC ASPIRATE CULTURE

	Number of Cases Observed	*Number of Positive Cases*	*Organisms*
Blood	7	5	Alpha Strep. 3 E. Coli 3 Klebsiella 1 C. Welchii 1 Staph. Albus 1
Gastric aspirate	3	3	Alpha Strep. 2 Klebsiella 2 E. Coli 1

Stool culture was consistently negative in all patients. Blood culture done in all 7 patients yielded positive results in 5. Culture of the gastric aspirate was obtained in 3. The most frequently encountered organism in the blood as well as in the gastric aspirate was Alpha Streptococcus, equally frequent was E. Coli in the blood and Klebsiella in the culture of the gastric aspirate. In 2 patients Alpha Streptococcus was found both in the blood and in the gastric aspirate. Other organisms involved included C. Welchii and Staphylococcus Albus. (Table IV)

The treatment given to the patients consisted of a combination of cessation of gastrointestinal feedings, intravenous antibiotics, providing nutrition by total parenteral alimentation and maintenance of fluid and electrolyte homeostasis. In addition, 4 patients received gentamycin through nasogastric or nasojejunal tubes, and 2 patients had been given breast milk before or during the onset of symptoms. Surgery was carried out in 3 patients because of either suspected or apparent perforation.

Two patients survived, constituting a survival

rate of 29%. The first (B.E.) was the only full term neonate in the group with a birth weight of 3430 gm. He had received breast milk prior to onset of symptoms. He also had the umbilical artery catheter placed at L_{2-3}. The catheter was removed 2 days after placement. He underwent surgery for perforation, and recovered after a stormy postoperative course.

The second survivor, T.L., was a twin born after 31 weeks of gestation and weighed 1191 gm at birth. The umbilical artery catheter had been placed at the level of T_8 and was removed after 3 days. She experienced an episode of abdominal distention, hematochezia and bilious vomiting at age 11 days and again at age 31 days, recovering from both. She had been given breast milk by nasogastric tube on the first day of abdominal distention. She developed a colonic stricture 8 weeks after the onset of her initial symptoms, underwent surgery elsewhere and died of postoperative complications.

COMMENTS

The cases reviewed in the present study seemed to occur in clusters, with a relative quiescence in 1973 and 6 out of 7 admitted in 1974. This may reflect the increase in total patient population in the expanded neonatal intensive care unit. However, similar observations of clustering were noted in two other institutions reporting at the Midwest Conference on Necrotizing Enterocolitis in Kansas City in February, 1975.[11] Both of them had relatively unchanged numbers of patients admitted to their units. The epidemiologic significance of this clustering is unclear.

The present study showed a high incidence of twins. This observation was concurred by Joshi, *et al*[12] and two other studies reported at the Midwest Conference on Necrotizing Enterocolitis.[11] This is not surprising, since twins carry a higher incidence of perinatal morbidity than singletons, and necrotizing enterocolitis is observed mostly in stressed neonates with a significant degree of morbidity.

The classical roentgenologic sign of pneumatosis intestinalis was an inconstant finding among the cases, present in only 1 of 7 patients. Bowel distention was a more common finding. Pneumatosis intestinalis, portal venous air and pneumoperitoneum have been considered diagnostic signs in necrotizing enterocolitis,[13] but to wait for these signs, one would be too late in diagnosing the disease. Soap bubble appearance in the Lumen or Linear air streaks indicating wall separation is now said to be diagnostic.[11]

The universal sign of abdominal distention was not always the earliest clinical sign observed in the present study. Bilious vomiting seemed to be a much earlier sign that was highly suggestive of acute necrotizing enterocolitis. This observation was also showed by several workers who reported at the Midwest Conference on Necrotizing Enterocolitis.[11]

The level of umbilical artery catheter placement in the first survivor was at L_{2-3}, seemingly suggesting some benefit over placing the catheter at a higher level. This is misleading. Experiences reported at the Midwest Conference showed the incidence of necrotizing enterocolitis in institutions where the tip of the umbilical catheter was routinely placed below the renal arteries in all patients was similar to that of the institutions where placement was at or above the diaphragm. Also, necrotizing enterocolitis has been reported in cases where umbilical vessels were not cannulated.[11]

In the present study Alpha Streptococcus seemed to be associated with necrotizing enterocolitis as frequently as were the gram negative organisms. It was not always present purely, often times found together with E. Coli or Klebsiella. The significance of its etiologic role is difficult to assess due to the small number of cases.

The intravenous fluids used in the treatment of the patient in the present study was given at a rate of 100 to 120 ml/kg/day. Other workers have used larger quantity of intravenous fluids up to 200 ml/kg/day. It was suggested at the Midwest Conference on Necrotizing Enterocolitis[11] that a larger volume of intravenous fluids given to high risk neonates seemed to reduce the incidence and mortality of acute necrotizing enterocolitis. Larger volume of intravenous fluid presumably corrects or prevents hypovolemia and hypotension (low flow syndrome) which have been considered as significant contributing etiologic factors. (See introduction)

The 2 survivors in the present study had received breast milk at some point prior to the onset of symptoms. The beneficial value of breast milk in rats to prevent induced necrotizing enterocolitis was suggested by the excellent and convincing work of Santuli.[14] Among other things, breast milk contains large amounts of IgA, smaller amounts of IgG, active lymphocytes and macrophages and specific antibodies against many

types of microorganisms (especially E. Coli). By feeding breast milk to the stressed neonatal rats, one probably provides protection by conferring to them immunologic competence. Studies on the prophylactic and/or therapeutic values of breast milk in humans are not yet available at present.

Since December, 1974, all premature neonates at Raymond Blank Memorial Hospital for Children receive 3-5 cc of fresh breast milk 3 to 4 times per day prior to starting any kind of gastrointestinal feeding. This procedure is carried out through nasogastric tubes even though the patients are on mechanical respiratory support. The breast milk was contributed fresh daily by healthy post-partum mothers from the obstetrical ward. To date, 5 months after this practice, there has been only one new case of suspected necrotizing enterocolitis. The patient subsequently died of an intracranial hemorrhage complicating an underlying respiratory distress syndrome. On autopsy, the involved segments of the alimentary tract were not necrotic and no longer severely inflamed.

There are many unanswered questions faced by the application of breast milk prophylaxis in necrotizing enterocolitis in humans. Should one use colostrum or breast milk? How fresh must the breast milk be to be effective? Should the breast milk be typed? If so, how? How can the breast milk be preserved without destroying its immunologic contents? All of these await further controlled studies.

SUMMARY

Seven cases of necrotizing enterocolitis were studied. The disease affected mainly stressed premature neonates and occurs in clusters. There was a high incidence of twins. The earliest clinical finding when present was bilious vomiting, preceding a persistent and progressive abdominal distention. Pneumatosis intestinalis was an inconstant and late roentgenologic finding. Alpha Streptococcus seemed to be present as frequently as the gram negative organisms in the cases studied. Breast milk seemed to have beneficial effects as noted in two survivors. These observations were correlated with the current understanding of necrotizing enterocolitis.

ACKNOWLEDGMENT

The authors wish to thank Drs. Lee Forrest Hill and L. A. Wintermeyer for their advice and encouragement in making this study possible and Mrs. Anne Harvey and Miss Carla Peterson for their assistance in the preparation of this manuscript.

REFERENCES

The references contained in this paper may be obtained either from the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

PEDIATRIC SESSION SET

The 20th Annual Pediatric Conference sponsored by the Raymond Blank Memorial Hospital for Children will be April 22 and 23 in Des Moines. Scientific sessions will be in the Jester Auditorium of the Iowa Methodist School of Nursing.

First day emphasis will be on pediatric neurology with guest speakers to include Gerald M. Fenichel, M.D., professor and chairman, Department of Neurology, Vanderbilt University; Robert V. Groover, M.D., Department of Neurology, Mayo Clinic; Arthur L. Prensky, M.D., professor of pediatrics and neurology, Washington University; and N. Paul Rosman, M.D., director of pediatric neurology, Boston University.

The second day will be concentrated on pediatric endocrinology with the following speakers scheduled: Robert G. Thompson, M.D., Department of Pediatrics, University of Iowa; Howard E. Kulin, M.D., associate professor of pediatric endocrinology, The M. S. Hershey Medical Center, Hershey, Pa.; Robert M. Blizzard, M.D., professor and chairman, Department of Pediatrics, University of Virginia, and H. Verdain Barnes, M.D., associate professor of medicine and pediatrics, University of Iowa.

The conference registration fee is $45. For further information, contact L. A. Wintermeyer, M.D., Iowa Methodist Medical Center, 1200 Pleasant, Des Moines 50308.

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Head and Neck Injuries in Football

Head and neck trauma from football contact deserves careful diagnostic attention. Four examples are cited to illustrate the various ways in which football injuries may occur.

PETER D. WIRTZ, M.D.
Des Moines

HEAD AND NECK injuries occur in football on a regular basis and the program at Drake University contributed several cases this past year. Most such injuries are musculo-skeletal strains of the cervical spine structures, but as the impact increases more serious and tragic injuries can occur.

The emphasis on head blocking, head tackling, and ball carrying with head down has contributed to the incidence of these injuries. Football regulations have restricted such tackling (spearing), and as the football helmet has been improved to protect the head, it has also become a weapon that often injures the wearer and not the struck player. The injured players reported in this paper were not specifically instructed in these techniques, but they all admit that these activities make them better blockers and runners.

The following are examples of head and neck trauma from football contact at Drake University during the 1975 season.

1. L.V., age 19, was injured on 10-25-75 in football contact as he blocked another player head on. He suffered acute pain at the time of the injury and had continuing pain into the right shoulder area. The physical examination revealed tenderness in the right trapezius muscle with full motion of the neck. The x-ray showed a stable compression fracture of the sixth cervical vertebra. Following the injury he has had healing of the fracture, relief of the pain, and continued full motion of the neck.

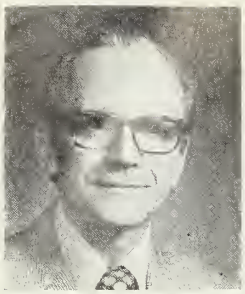
2. P.F., age 21, was injured on 11-8-75 while intentionally tackling another player head on. He had acute pain for approximately one-half hour which gradually resolved but continued to have bilateral shoulder pain and stiffness of the neck. His initial examination showed him to have exquisite pain in the lower base of the neck with extension of the neck, and full range of motion. The x-ray showed a stable compression fracture of the sixth cervical vertebra. Since the injury the fracture has healed, the pain has subsided and he has had continued full range of motion.

3. R.B., age 19, was injured on 11-15-75 while he was trapped in an offensive maneuver and he was struck on the top of his helmet by another player's chest. He was unconscious for approximately 30 seconds which resolved itself with continuing headache. His headaches continued for a 48 hour period and following that have not recurred. The x-rays of the cervical spine have been within normal limits. Following the clearing of his headaches, he has had no further symptoms.

4. M.C., age 19, had an onset of numbness in the left thumb and index finger while standing on the practice field on 11-18-75. The patient does not give any specific history of direct trauma to the head but being a center he has to tackle and block in such a manner. He noted pain with extension of the neck as well as left rotation of the neck. Examination showed that his left rotation was limited and he also had a decrease in the biceps jerk on the left side. The sensory deficit was noted to be at the tip of the index finger from the distal interphalangeal joint distally, as well as the distal end of the thumb from the interphalangeal joint. The x-rays on 11-20-75

(Please turn to page 102)

Dr. Wirtz is in the private practice of orthopedic surgery in Des Moines. He serves as team physician for Drake University.



Editorials

M. E. ALBERTS, M.D., Scientific Editor

ANNUAL SCIENTIFIC MEETING

The 1976 Annual Scientific Session of the Iowa Medical Society convenes in Iowa City on April 6, 7 and 8. Will you be there? The program has something for everyone. Are you becoming doubtful about some of the diagnostic procedures you still do? There will be a panel discussion on "Tests Not Worth Doing Anymore." Does your interest lie in acute myocardial attacks? A splendid panel has been arranged for discussion of that subject. There will be several seminars, each to be repeated, so one can attend two of these—on chronic lung disease, urinary problems, gynecology, chemotherapy of malignancies, and rheumatoid disease. Perhaps the plight of the adolescent interests you. Study the program. Surely you will find it to be well-planned and of value to most physicians. Make your reservations early. —M.E.A.

ARE THE RISKS TOO HIGH?

Our society now recognizes more than ever the concept of equality for all. The rights of the individual are protected by law. Women have worked hard to be liberated. Yet, there is one area where it appears to me they are receiving a very unrealistic victory, if it can be called a victory. I refer to the area of birth control.

One cannot argue that birth control is unnecessary. Our population is exceeding the boundaries, and if we cannot control population growth, future generations shall suffer immeasurably. Yet, it seems the great burden of birth control falls upon the female of the species, and she must resort to various devices, or the pill, or surgery to render herself sterile. Some men, of course, resort to vasectomy, but I am sure their numbers are far fewer than those women who engage in some form of control.

Reports in the literature about the consequences of the intrauterine devices and the effects of the pills are frightening. I shall always remember (1) the pathologic specimen in a cabinet at medical school—a uterus with an imbedded silver device which was to control conception, and (2) the frequent admonitions of the professors about insertion of such gadgets. Now, again there are admonitions about IUD's causing tubo-ovarian abscesses. One study estimates 3-10 cases/1,000 woman-years of use, and 22-45 deaths/million users/year.

The contraceptive pill is not without serious complications. The complications include venous thromboembolism, thrombotic stroke, hypertension, myocardial infarction, and more recently gall bladder disease due to elevated cholesterol levels. The complications occur in 1/1,000 woman-years use and deaths are estimated at 2.2-9.8/million woman-years of use. Apparently, the balance of nature, the hormonal levels of the female physiology, are so deranged that these complications result. Even during menopause, the provision of estrogens to relieve symptoms leads to possible gall bladder disease and endometrial cancer.

Tubal ligation remains another method of birth

(Please turn to page 104)

A BICENTENNIAL COMMEMORATION

IOWA MEDICAL SOCIETY 1976 SCIENTIFIC SESSION

TUESDAY, WEDNESDAY, THURSDAY

APRIL 6,7,8

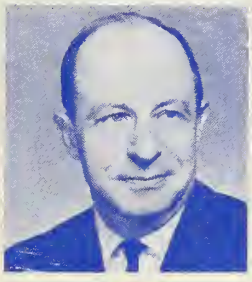
IOWA CITY

THE HIGHLANDER INN / UNIVERSITY OF IOWA COLLEGE OF MEDICINE

INVITATION FROM THE PROGRAM COMMITTEE

The 1976 Iowa Medical Society Program Committee is pleased to submit this three-day education program for your consideration. In the 48-hour period covered by the program, participants will be exposed to meaningful and diversified material which is aimed at helping them serve the people of Iowa with greater knowledge and skill. We sincerely hope you will attend.

L. O. ELY, M.D.
Chairman, Des Moines



C. W. BECKMAN, M.D.
Kalona

R. M. CAPLAN, M.D.
Iowa City

J. F. ROULES, M.D.
Mediapolis

W. B. GALBRAITH, M.D.
Cedar Rapids

The continuing medical education program described on the following pages is available to member physicians of the Iowa Medical Society. The program is accredited for 14 prescribed hours by the American Academy of Family Physicians and Category I credit toward the AMA Physician Recognition Award. The Registration Desk will be open to answer questions and serve participants.

Physicians anticipating emergency telephone calls should note the following numbers: Tuesday and Thursday—800/272-6444 (Toll Free/The Highlander); Thursday—319/353-5763.

DR. SCHLASER

DR. ECKSTEIN

DR. KOEPKE

DR. SCHRANTZ

DR. ROSE

DR. FELDICK

DR. FISCHER

DR. IANNONE

DR. PHILLIPS

DR. ELIOT

TUESDAY, APRIL 6

11:00 A.M.—REGISTRATION
The Highlander Inn

1:00 P.M.—GENERAL SESSION
Piper Ballroom/First Floor

WELCOMING REMARKS

VERNE L. SCHLASER, M.D.
Des Moines
President, Iowa Medical Society

JOHN W. ECKSTEIN, M.D.
Iowa City
Dean, College of Medicine
University of Iowa

All speakers with an academic designation are members of the faculty of the University of Iowa, College of Medicine unless otherwise noted.

1:15 P.M.—PRESCRIBING PRACTICES OF PHYSICIANS

F. WILLIAM BENNETT, M.D.
Cedar Rapids
Chairman, Drug Abuse Committee
Iowa Medical Society

1:35 P.M.—THERAPEUTIC BLOOD LEVELS OF DRUGS, THEIR BASIS & USE

LAWRENCE J. FISCHER, Ph.D.
Associate Professor
Department of Pharmacology

2:00 P.M.—TESTS NOT WORTH DOING ANY MORE

JOHN A. KOEPKE, M.D.
Professor and Vice Chairman
Department of Pathology

ROBERT D. SCHRANTZ, M.D.
Ottumwa, Iowa
Private Practice/Pathology

EARL F. ROSE, M.D.
Professor
Department of Pathology

ROLF L. SCHAPIRO, M.D.
Associate Professor
Department of Radiology

2:45 P.M.—PROPER CARE & EXAMINING OF THE SEXUALLY ASSAULTED PERSON

EARL F. ROSE, M.D.
Professor
Department of Pathology

HARLEY FELDICK, M.D.
Director of Student Health

FRANK ZLATNIK, M.D.
Assistant Professor
Department of Obstetrics & Gynecology

KATHY GORMAN
Iowa City Police Department

3:15 P.M.—RECESS/COFFEE BREAK

3:30 P.M.—ACUTE MYOCARDIAL ATTACKS

The Pathophysiologic Setting of Early Myocardial Necrosis
ROBERT S. ELIOT, M.D.
Omaha, Nebraska
Director of Cardiovascular Center and Division of Cardiovascular Medicine, University of Nebraska Medical Center

Results of Coronary Catheterization In Acute Myocardial Attacks
LIBERATO A. IANNONE, M.D.
Des Moines, Iowa
Private Practice/Internal Medicine

Results of Emergency Direct Coronary Artery Revascularization for Evolving Acute Myocardial Infarction
STEVEN J. PHILLIPS, M.D.
Des Moines, Iowa
Private Practice/Surgery

Reduction of the Size of Myocardial Infarction: Experimental & Clinical Correlations
DONALD B. DOTY, M.D.
Associate Professor
Department of Surgery

Panel Discussion: The Treatment of Acute Myocardial Attacks

5:00 P.M.—ADJOURNMENT

TUESDAY, APRIL 6

RECEPTION FOR PHYSICIANS AND THEIR SPOUSES

SPONSORED BY UNIVERSITY OF IOWA ALUMNI ASSOCIATION & COLLEGE OF MEDICINE

6:00 p.m. to 7:30 p.m.
Piper Ballroom, Highlander Inn

DR. DOTY

DR. YOUNG

DR. McSHANE

DR. KASIK

DR. BEDELL

DR. SMITH

DR. FANESTIL

DR. DiBONA

DR. WETRICH

DR. RICHARDS

DR. CHAPLER

DR. KEETTEL

DR. FAJANS

DR. GALASK

DR. CORDER

DR. BURNS

DR. JOCHIMSEN

DR. SUMMERS

WEDNESDAY, APRIL 7

All Wednesday sessions will be presented at University Hospitals.

8:00 A.M.—REGISTRATION
University Hospitals
Medical Alumni Auditorium/E331

8:00 A.M.—PREMATURE VENTRICULAR BEAT: WHEN TO TREAT
Medical Alumni Auditorium/E331

ROBERT S. ELIOT, M.D.
Omaha, Nebraska
Director of Cardiovascular Center and Division of Cardiovascular Medicine, University of Nebraska Medical Center

9:00 A.M.—THE EARLIER DIAGNOSIS OF BREAST CANCER
Erskine Memorial Lecture

DONALD C. YOUNG, M.D.
Des Moines, Iowa
Private Practice/Radiology
Project Director/Demonstration Project for Earlier Detection of Breast Cancer

9:30 A.M.—IMPROVE YOUR TISSUE & SUTURE TECHNIQUES

RICHARD H. McSHANE, M.D.
Assistant Professor/Division of Plastic Surgery

10:00 A.M.—RECESS/COFFEE BREAK

10:15 A.M.—DOCTOR'S CHOICE

I. CHRONIC OBSTRUCTIVE LUNG DISEASE
Medical Alumni Auditorium/E331

Office Management of Chronic Obstructive Airways Disease
JOHN E. KASIK, M.D. (Moderator)
Professor/Department of Internal Medicine

Recent Advances in Drug Therapy of Asthma & Other Bronchia Restrictive Diseases
GEORGE BEDELL, M.D.
Professor/Department of Internal Medicine

The Therapy of Acute Respiratory Failure
JAN D. SMITH, M.D.
Assistant Professor/Department of Internal Medicine

II. THE PATIENT WHO MAKES NO URINE
Anesthesiology Conference Room/SE635

GERALD F. DiBONA, M.D. (Moderator)
Professor/Department of Internal Medicine

Differential Diagnosis of Oliguria
DARRELL D. FANESTIL, M.D.
La Jolla, California
Professor of Medicine & Head, Division of Nephrology, University of California/San Diego School of Medicine

The Acute Problems—Fluid Overload, Hyperkalemia & Acidosis
RICHARD M. FREEMAN, M.D.
Professor/Department of Internal Medicine

Dialysis Therapy
CARL J. RICHARDS, M.D.
Assistant Professor/Department of Internal Medicine

DR. BARKER

DR. RHODES

III. OBSTETRICS & GYNECOLOGY
Peterson Conference Room/E140

Recent Advances in Technics of Female Sterilization
WILLIAM C. KEETTEL, M.D. (Moderator)
Professor & Head/Department of Obstetrics & Gynecology

Do's & Don'ts with the Oral Contraceptive
F. K. CHAPLER, M.D.
Associate Professor/Department of Obstetrics & Gynecology

How Should the DES Exposed Female Be Followed?
WALTER C. FRIDAY, M.D.
Burlington, Iowa
Private Practice/Obstetrics & Gynecology

DAVID W. WETRICH, M.D.
Ottumwa, Iowa
Private Practice/Obstetrics & Gynecology

Recurrent Vaginal Infections
RUDOLPH P. GALASK, M.D.
Assistant Professor/Department of Obstetrics & Gynecology

DR. THOMPSON

DR. PITKIN

DR. BARNES

DR. DONTA

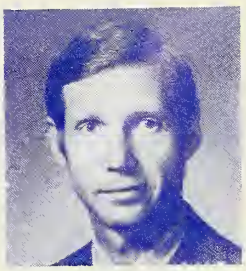
DR. TYRRELL

DR. MOYERS

11:15 A.M.—RECESS

11:20 A.M.—REPEAT DOCTOR'S CHOICE SESSIONS

12:20 P.M.—DUTCH TREAT LUNCHEON
Doctors' Dining Room
Tickets May Be Purchased at Registration Desk.



DR. RAKEL

DR. RAOCLIFFE

DR. BLODI

DR. VAN ALLEN

DR. McCABE

DR. COOPER

DR. WINOKUR

DR. LAUER

DR. OEN BESTEN

DR. CULP

1:30 P.M.—ORAL HYPOGLYCEMIC AGENTS
General Session—Medical Alumni Auditorium/E331

STEFAN S. FAJANS, M.D.
Ann Arbor, Michigan
Professor of Internal Medicine;
Head, Division of Endocrinology & Metabolism;
Director, Metabolism Research Unit,
University of Michigan
Baldridge-Beye Memorial Lecture
Sponsored by Scanlon Medical Foundation/IMS

2:00 P.M.—RELATIONSHIP OF STRESS & HEART DISEASE

ROBERT S. ELIOT, M.D.
Omaha, Nebraska
Director of Cardiovascular Center and
Division of Cardiovascular Medicine
University of Nebraska Medical Center

2:45 P.M.—RECESS/COFFEE BREAK

3:00 P.M.—DOCTOR'S CHOICE

IV. RHEUMATOLOGY & JOINT PROSTHESIS
Medical Alumni Auditorium/E331

MERLIN P. STROTTMAN, M.D. (Moderator)
Associate Professor/Department of Internal Medicine

V. CHEMOTHERAPY
Wm. Bean Conference Room/SE301

Chemotherapy for Carcinoma of the Breast
MICHAEL P. CORDER, M.D. (Moderator)
Assistant Professor & Director/Section of Oncology, Department of Internal Medicine

Treatment of Acute Leukemia
C. PATRICK BURNS, M.D.
Associate Professor/Department of Internal Medicine

Chemotherapy for Gastro-Intestinal Malignancies
PETER R. JOCHIMSEN, M.D.
Assistant Professor/Department of Surgery

VI. NEW USES OF FIBEROPTICS IN MEDICINE
Peterson Conference Room/E140

Colonoscopy
ROBERT W. SUMMERS, M.D. (Moderator)
Associate Professor/Department of Internal Medicine

Upper Gastrointestinal Endoscopy Common & Pancreatic Cannulization
JOHN D. BARKER, JR., M.D.
Associate/Department of Internal Medicine

Bronchoscopy
MITCHELL L. RHODES, M.D.
Associate Professor/Department of Internal Medicine

Laparoscopy
FREDERICK K. CHAPLER, M.D.
Associate Professor/Department of Obstetrics & Gynecology

Arthroscopy
RICHARD A. BRAND, M.D.
Assistant Professor/Department of Orthopaedics

4:00 P.M.—RECESS

4:10 P.M.—HYPOGLYCEMIA
General Session—Medical Alumni Auditorium/E331

STEFAN F. FAJANS, M.D.
Ann Arbor, Michigan
Professor of Internal Medicine;
Head, Division of Endocrinology & Metabolism;
Director, Metabolism Research Unit,
University of Michigan

5:00 P.M.—ADJOURNMENT

WEDNESDAY, APRIL 7
6:00 P.M.

RECEPTION FOR PHYSICIANS AND SPOUSES
The Highlander Inn (Cash Bar)

7:00 P.M.

BANQUET AND ENTERTAINMENT
Piper Ballroom

The University of Iowa Old Gold Singers

Banquet Tickets Will Be Sold at the Registration Desk on Tuesday and Wednesday.

THURSDAY, APRIL 8

8:00 A.M.—REGISTRATION
The Highlander Inn

8:30 A.M.—ADOLESCENT MEDICINE
General Session—Piper Ballroom

What It Takes to Care for Teenagers
H. VERDAIN BARNES, M.D.
Associate Professor/Departments of Internal Medicine & Pediatrics, Director of Adolescent Medicine

Delayed Puberty
ROBERT THOMPSON, M.D.
Associate Professor/Department of Pediatrics

Adolescent Pregnancy
ROY PITKIN, M.D.
Professor/Department of Obstetrics & Gynecology

Venereal Disease in the Adolescent
SAM DONTA, M.D.
Associate Professor/Department of Internal Medicine

9:30 A.M.—THE PLEASURES & PAINS OF HOSPITAL STAFF MEMBERSHIP

LAWRENCE O. ELY, M.D.
Des Moines, Iowa
Private Practice/Surgery

9:45 A.M.—IOWA'S HEALTH SYSTEMS AGENCY

JOHN E. TYRRELL, M.D.
Manchester, Iowa
Vice President/Board of Directors
Iowa Health Systems Agency

10:00 A.M.—RECESS/COFFEE BREAK

10:15 A.M.—NUTRITIONAL & DIETARY FADS & FANTASIES

HELMUT G. SCHROTT, M.D. (Moderator)
Assistant Professor/Department of Internal Medicine
(Additional Speakers Will Form a Panel)

11:00 A.M.—WHAT'S NEW IN MEDICINE?

College of Medicine Department Heads

RICHARD M. CAPLAN, M.D. (Moderator)
Associate Dean,
Continuing Medical Education

Anesthesiology
JACK MOYERS, M.D.
Professor and Head

Dermatology
CHRISTIAN RADCLIFFE, M.D.
Professor and Vice Chairman

Family Practice
ROBERT RAKEL, M.D.
Professor and Head

Neurology
MAURICE VAN ALLEN, M.D.
Professor and Head

Obstetrics & Gynecology
WILLIAM KEETTEL, M.D.
Professor and Head

Ophthalmology
FRED BLODI, M.D.
Professor and Head

Orthopaedic Surgery
REGINALD COOPER, M.D.
Professor and Head

Otolaryngology and Maxillofacial Surgery
BRIAN McCABE, M.D.
Professor and Head

Pediatrics
RONALD LAUER, M.D.
Professor and Vice Chairman

Psychiatry
GEORGE WINOKUR, M.D.
Professor and Head

Surgery
LAWRENCE DEN BESTEN, M.D.
Professor and Vice Chairman

Urology
DAVID CULP, M.D.
Professor and Head

NOON—CONCLUDING REMARKS

VERNE L. SCHLASER, M.D.
President, Iowa Medical Society

SPECIAL THANKS

The Iowa Medical Society extends appreciation to the following companies which have provided educational grants in support of the 1976 Scientific Session:

A. H. ROBINS COMPANY—BLUE SHIELD—BRISTOL LABORATORIES
CIBA PHARMACEUTICAL COMPANY—ELI LILLY AND COMPANY—E. R. SQUIBB & SONS, INC.
GEIGY PHARMACEUTICALS—MERCK SHARP & DOHME—MERRELL LABORATORIES
PARKE, DAVIS & COMPANY—THE UPJOHN COMPANY—WINTHROP LABORATORIES

Appreciation is also extended to Blue Shield for sponsoring the coffee functions for physicians and their spouses, and to The University of Iowa Alumni Association and College of Medicine for hosting the reception on Tuesday, April 6. The Society is grateful for this support.

SPECIAL EVENTS

IOWA ACADEMY OF FAMILY PRACTICE—The Family Practice Club will meet at 7:30 p.m., Tuesday, April 6, at the University Athletic Club. A panel discussion on professional liability is planned. Refreshments will be available following the program.

SPECIAL IMS AUXILIARY PROGRAM—The IMS Auxiliary will have a workshop at 10 a.m. Wednesday, April 7, in the Gold Room at The Highlander. This will be followed at noon with a poolside luncheon. Guest speaker will be Robert Eliot, M.D., Omaha, Nebraska.

TUESDAY RECEPTION—A special reception for physicians and spouses will take place Tuesday, April 6 at The Highlander from 6 to 7:30 p.m. through the courtesy of the University of Iowa Alumni Association and College of Medicine.

ALPHA OMEGA ALPHA—Members of Alpha Omega Alpha, national honorary medical society, are cordially invited to attend Initiation and Dinner at 7:30 p.m., Tuesday, April 6, at the Highlander Inn Supper Club. Reservations are necessary and contact should be made with Joseph A. Schmidt, M.D., Department of Urology, University Hospitals, Iowa City, Iowa 52242. Telephone—319/353-6921. Dinner tickets may be purchased at Registration. Guest speaker to be announced.

IOWA CHAPTER/AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS—IOWA OBSTETRICAL AND GYNECOLOGICAL SOCIETY—These organizations will have a luncheon at 12:30 p.m., Thursday, April 8, at the Highlander. For reservations contact Robert Kretzschmar, M.D. Department of Obstetrics and Gynecology/University Hospitals, Iowa City. Telephone—319/356-3605.

Burn Unit of the University of Iowa: First Five Years

WILLIAM C. BOYD, M.D., and
CHARLES E. HARTFORD, M.D.
Iowa City

In five years the U of I Burn Unit has treated 567 patients. Results of this treatment are summarized with note made of new therapy modalities which may improve the picture further.

The Burn Unit of the University of Iowa was opened in September, 1969. It was established under the foresighted leadership of R. T. Tidrick, M.D., former professor and head, and S. E. Ziffren, M.D., current professor and head, Department of Surgery, to provide optimum care to the large number of burned victims referred to University Hospitals. This report describes the basic treatment program and evaluates the results which have been realized in five years of operation.

TREATMENT PROGRAM

Fluid Resuscitation

Fluid resuscitation to prevent or treat burn shock has been accomplished using either a balanced salt solution (lactated Ringer's solution) alone or a balanced salt solution to which albumin has been added to make a 2.3% solution.[1] Patients with larger burns, infants and the aged with smaller burns and those with compromised cardiovascular, respiratory or renal function have been treated with the crystalloid-colloid mixture. The volume of fluid given has been based on the patient's clinical response to treatment and not dictated by a formula.

The Burn

The burns have been covered with dressings kept continuously wet with 0.5% silver nitrate. These dressings have been changed at least once each day. In 1974 we began to treat smaller burns with topically applied silver sulfadiazine. In most instances, patients received a tub bath once each day during which time loose eschar has been removed. When the eschar has almost completely separated and it becomes apparent that skin grafting will be required, debridement has been completed in the operating room with the patient anesthetized, usually with ketamine hydrochloride. Debrided wounds prior to autografting have been protected with a biological dressing. Cadaver homograft skin was used until 1970 when the demand became excessive. We have subsequently used commercially prepared porcine xenograft skin. Those wounds requiring skin grafts have been grafted as early as possible. To obtain skin expansion generous use has been made of the Tanner-Vandeputt technique of meshing skin.[2]

Antibiotics

During the period of fluid resuscitation penicillin has been administered intravenously to prevent Group A β-hemolytic streptococcal sepsis. Following this an oral penicillinase resistant penicillin has been given during the patient's entire hospital stay. Antibiotics against gram-negative bacteria and fungi have been given to patients with burns larger than 30% of the body surface area and also to those with smaller burns for the specific indication of invasive infection.[3]

Inhalation Injury

Those patients with inhalation injury requiring

* Dr. Boyd is an assistant professor in the Department of Surgery at the University of Iowa College of Medicine. Dr. Hartford is an associate professor in the Department of Surgery and Director of the Burn Unit.

TABLE I

Year	Patients Admitted*	Average Percent Burn†	Deaths
1 (9/69-8/70)	128	24.6	21‡
2 (9/70-8/71)	126	22.7	15
3 (9/71-8/72)	94	24.5	16
4 (9/72-8/73)	103	23.0	10
5 (9/73-8/74)	112	29.8	15
	563		77

* Does not include two patients whose charts could not be located and two patients who were transferred to institutions outside the state of Iowa.

† Does not include patients with electrical injury.

‡ Includes the one patient who died of electrical injury.

ventilatory support have been cared for in the Surgical Intensive Care Unit where the patient's pulmonary care has been directed by physicians skilled in this aspect of medical care.

Electrical Injury

Electricity causes an injury which typically results in deep necrosis of large masses of muscle beyond the obvious skin injury. Therefore, these patients have been treated differently. If necrosis of muscle did occur, these areas have been excised in the operating room, usually during the first week after injury.[4]

RESULTS

Five hundred sixty-seven patients with acute burns were admitted during the five year period ending August, 1974. Because the charts of two patients could not be located and two patients were transferred to institutions outside the State of Iowa early in their post burn course, 563 patients form the basis of this report.

The number of patients admitted, the average size of burn* and the number of deaths for each year are shown in Table 1. There have been no significant or consistent trends in these three items.

Because patients with electrical injury were usually managed differently than those patients with burns caused by other sources of heat, the two groups have been separated for analysis.

Electrical Injury

There were 25 patients with electrical injury. All were young productive or potentially productive males with an average age of 23.8 years, range 4-48 years. Most were injured by high tension current (i.e., greater than 1,000 volts) and most of the accidents occurred at work. One-third required a major amputation ranging in severity from an important functional part of one hand to two extremities. Two patients had major neurological sequelae. The average length of hospital stay for the 24 survivors was 35 days. The one death resulted from an overwhelming injury which destroyed the chest and abdominal walls and three extremities.

TABLE II

Distribution of Patients by:							
Sex		Age* Years		Size of Burn* Percent Burn		Source of Heat	
Males	395	0-<2	43	0-9	152	Flame	399
Females	168	2-9	101	10-29	225	Scald	94
		10-39	245	30-59	94	Heat Contact†	29
		40-59	80	60-79	43	Chemical	14
		60+	69	80-100	24	Sunburn	1
						Friction	1
						Electricity	25

* Excludes patients with electrical injury.

† Includes patients injured by grease and molten metals.

TABLE III

AVERAGE HOSPITAL STAY OF SURVIVORS*

Percent Burn	Days
0-9	15
10-29	32
30-59	48
60-79	85
80-100	No Survivors

* Excludes patients with electrical injury.

Thermal Injury Other Than Electrical

The remaining 538 patients (Table II) were burned by flame (74%), scalding liquids (17%), heat contact (5%), chemical (3%), exposure to sun (one patient) and friction (one patient). The latter patient fell onto a conveyor belt which caused a friction burn of 9% of his body surface area, involving the right shoulder joint and destroying the right wrist. Table II also shows the distribution of patients by sex, age and size of burn. These data are similar to other reported

* Surface area involved by second and third degree burns calculated by the technique of Lund and Browder.[5]

series. As a group these patients spent about one and one-half days in the hospital for each percent of burn. However, there was a wide range of duration of hospital stay, 1-122 days. Many patients with smaller burns spent only 1-2 days in the hospital. Those patients who did not require skin autografts had shorter hospital stays than those who required skin autografts.

Figure 1 shows mortality as a function of age and extent of burn. To aid in the discussion of results, the Figure is divided into three areas—unshaded, cross-hatched and shaded.

The unshaded area represents that group of patients who, based on size of burn, age and/or treatment rendered, were virtually assured of survival. This group contained 416 or 77% of the 538 patients treated. Eight of these patients died. Most were from unusual causes of deaths for burn patients such as direct thermal injury to the brain, trauma incurred from an automobile accident, or among the aged, degenerative diseases.

The 76 patients, 14% of the 538 patients, in the cross-hatched area of Figure 1 had a mortality rate which ranged from 27-50%. While this mortality or rate of survival compares favorably with that of other burn programs,† some of the patients in this group who died were potentially salvagable. These patients' burns were neither large enough nor distributed in such a way to cause early death, but their metabolic reserve and/or the treatment rendered was not good enough to allow survival. Most of the deaths were a sequelae of sepsis, still the most frequent cause of death of a burned patient.

The 46 patients, 9% of the 538, in the shaded area of Figure 1 had, in our unit, virtually no chance for survival. Because of extremely large and deep burns and/or an elderly age, most of these patients could not be effectively resuscitated and died within several days of their injury.

COMMENT

The relatively inexpensive initial cost ($93,158 to remodel and equip a hospital ward) of this 12-bed Burn Unit and its equipment belies the tremendous benefit derived in patient care, resident and student education and the generation of new knowledge.

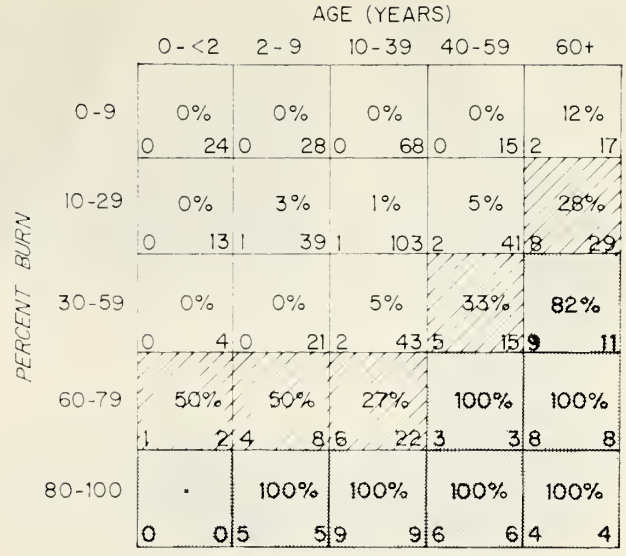


Figure 1. Five hundred thirty-eight patients admitted between September, 1969 and August, 1974. Excludes patients with electrical injury. In each cell the number of patints is in the right lower corner, the number of deaths is in the left lower corner, and the percent mortality is in the center. See text for discussion.

While there is always room for improvement, there is currently little justification for changing the treatment regimen for the majority of the burned patients who will be admitted. We do believe, however, that we need to explore new or supplementary modalities of therapy for certain of those patients who fall into the cross-hatched area of Figure 1 and for those patients with greater than 80% body surface burn who are less than 40 years of age whose mortality is currently 100%. We believe some of these patients are potentially salvagable.

Therefore, in an attempt to further enhance survival, we plan to treat selected patients from these groups in isolation, with early staged excision of the burn, providing coverage of excised areas with donor related homograft skin and possibly with immunosuppressants. Investigational work is underway to better understand methods of controlling invasive infection.

SUMMARY

The first five years experience of the Burn Unit of the University of Iowa is reviewed. The treatment program used is outlined, results tabulated and analyzed and new modalities of therapy which might improve survival are presented.

(References Appear on Page 106)

† Since July, 1971, data of the Burn Unit of the University of Iowa has been submitted to the National Burn Information Exchange.[7] For patients treated at the University of Iowa the LA_{50} for all ages was 62±8. LA_{50} is derived by probit analysis and is the size burn at which one-half of the patients live and one-half die.

HEAD AND NECK INJURIES IN FOOTBALL

(Continued from page 89)

showed that there was anterior displacement of the pharyngeal soft tissue structures which had cleared by 12-12-75. The patient continues to have numbness in his fingers but has no pain in his neck and has had return of full motion of his neck.

The fractures and the head concussion have cleared without apparent residuals. The last case of the residual symptomatology has not cleared and will probably require a surgical correction in the near future. The common symptomatology associated with these problems is the persistence of neck pain and stiffness for a one to two week period of time.

Regardless of the level of football competition, the persistence of neck stiffness or pain in an injured athlete signals the possibility of such injuries and will require appropriate diagnostic procedures.

APRIL CONFERENCE ON SPORTS

A Conference on the Medical Aspects of Sports will be presented Thursday, April 8, in Des Moines under the co-sponsorship of the Iowa Medical Society and the Iowa High School Athletic Association. Site of the meeting will be the Jester Auditorium of the Iowa Methodist School of Nursing.

Keynote speaker for the one-day conference will be Kenneth D. Rose, M.D., of Lincoln, Nebraska. Dr. Rose's topic will be "Total Fitness for Athletic Competition."

The meeting is arranged for junior high and high school coaches and trainers and interested physicians. It is the third in a series of every-other-year conferences coordinated by the IMS Committee on Sports Medicine and the IHSAA.

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Educationally Speaking

by RICHARD M. CAPLAN, M.D.

ARE YOU A SLAVE DOCTOR?

Since we have no human slaves close at hand anymore, you may well wonder what I mean by my opening question. Yes, the term "slave doctor" here has a special meaning, actually a double meaning. The description is in the dialogue of Plato called "Laws." As in so many areas of human affairs, Plato's thoughts seem amazingly contemporary, even if the Jowett translation provides an archaic flavor. Read this passage and see if you think you are a slave doctor in the senses used there. If you decide you are and feel you'd rather not be, it's possible to make a change, even though difficult. Continuing education may be helpful.

Ath. . . . *offering never a word of advice or exhortation, after the manner of some doctors? For of doctors, as I may remind you, some have a gentler, others a ruder method of cure. . . . What I mean to say is, that besides doctors there are doctors' servants, who are also styled doctors.*

Cle. *Very true.*

Ath. *And whether they are slaves or freemen makes no difference; they acquire their knowledge of medicine by obeying and observing their masters; empirically and not according to the natural way of learning, as the manner of freemen is, who have learned scientifically themselves the art which they impart scientifically to their pupils. You are aware that there are these two classes of doctors?*

Cle. *To be sure.*

Ath. *And did you ever observe that there are two classes of patients in states, slaves and freemen; and the slave doctors run about and cure*

(Please turn to page 104)

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

UNIQUE TELEPHONIC PROGRAM

A new venture in continuing medical education will occur in Iowa during March. The unique CME project is called "Three Evenings of Dialogue About Cancer" and will seek to inform clinicians about new developments in oncology.

On successive Tuesdays (March 9, 16 and 23) at 8 p.m., a TEL-E-NETWORK—a telephone system connecting the 16 Iowa Area Schools—will be given over to this pilot series of telephoned lectures-conferences. The opportunity will be available for questions and responses from each of the 16 sites. The project is a joint endeavor of the University of Iowa College of Medicine, the Iowa Area Colleges and the State Department of Public Instruction.

The series is approved for 6 hours of credit by the American Academy of Family Physicians as well as 6 hours of credit for the Physician's Recognition Award.

The programs will cover gynecologic cancers, breast cancer and the epidemiology of environmental cancer. It will include consideration of illustrative material at each site.

Additional information may be obtained from Richard M. Caplan, M.D., Associate Dean for Continuing Medical Education, University of Iowa College of Medicine.

EDUCATIONALLY SPEAKING

(Continued from page 103)

the slaves, or wait for them in the dispensaries—practitioners of this sort never talk to their patients individually, or let them talk about their own individual complaints? The slave-doctor prescribes what mere experience suggests, as if he had exact knowledge; and when he has given his orders, like a tyrant, he rushes off with equal assurance to some other servant who is ill; and so he relieves the master of the house of the care of his invalid slaves. But the other doctor, who is a freeman, attends and practices upon freemen; and he carries his enquiries far back, and goes into the nature of the disorder; he enters into discourse with the patient and with his friends, and is at once getting information from the sick man, and also instructing him as far as he is able, and he will not prescribe for him until he has first convinced him; at last, when he has brought the patient more and more under his persuasive influences and set him on the road to health, he attempts to effect a cure. Now which is the better way of proceeding in a physician?

EDITORIALS

(Continued from page 90)

control, and now many women speak of their "bandaid surgery." This does not provide 100% assurance of sterility but for the most part is effective, akin to vasectomy for the male. Yet, this is surgery, and now our society is screaming about unnecessary surgery with its attendant risks.

The time-honored forms of birth control (diaphragms, jellies, condoms, rhythm method) are less reliable. Total denial is sure, but not acceptable. That leaves us with the question about the risks. Are they too high? Can other methods be devised to control the possibility of pregnancy? Will the pills for men be acceptable? Will they cause imbalance of male hormones and lead to complications? Will men accept these risks? There are many questions to be answered. Only time and experience will provide the answers. We must know the answers fully to provide good professional advice. Judicious prescription of these drugs, as well as all other medicinals, is mandatory. Continued research and close attention to incidence of complications must be ongoing in order to learn more of possible risks. If the risks become too high, the use of such drugs must be denied.—M.E.A.

IOWA MEDICAL MISCELLANY

(Continued from page 77)

CME SITE SURVEY . . . A Des Moines hospital will be first Iowa facility to receive a site visit from IMS Committee on Medical Education and Hospitals under new program which grants accreditation status for continuing medical education activities. If approved, the hospital's CME programs will qualify automatically for Category I credit for the AMA Physicians Recognition Award.

INSTALLED . . . Donald L. Taylor, executive advisor to the Iowa Medical Society, was installed recently as president of the Professional Convention Management Association, a national body with over 180 member organizations from the medical, dental, hospital and allied professions.

HEALTH SCREENING . . . A health screening program offered by Farmland Industries to its local coops has involved approximately 30 Iowa communities. The testing is provided by American Health Profiles, Inc., from a mobile unit. IMS has urged AHP to contact county society presidents and/or secretaries prior to program.

SPECIALTY BRIEFING . . . IMS briefing for officers of Iowa medical specialty groups occurred February 18 at Society headquarters.

IMMUNIZATION . . . IMS Committee on Maternal and Child Health met March 3 to review legislation to make immunization a requirement for entry into school.

State Department of Health

BIOLOGICALS & ANTIBIOTICS AVAILABLE THROUGH THE STATE DEPARTMENT OF HEALTH

Several biologicals, antibiotics, and related products pertinent to the diagnosis, prevention and treatment of specific infectious diseases are available to health practitioners in the State of Iowa through the Division of Disease Prevention, Iowa State Department of Health. All are currently licensed products obtained through standard American commercial sources or from depot stocks maintained by the U. S. Center for Disease Control. These materials are listed here according to their general nature and use. Such materials are often provided free of charge when pertinent to a disease problem of public health significance or when reimbursement seems unreasonable.

For further information as to specific policies and procedures for the distribution of these products, interested parties should write to the Chief, Division of Disease Prevention, Iowa State Department of Health, Lucas State Office Building, Des Moines, Iowa 50319, or Telephone: 515/281-5424.

I. VACCINES, for ACTIVE IMMUNIZATION, by disease:

A. STANDARD ISDH STOCK, for "Routine Use"
1. Diphtheria and Tetanus Toxoids and Pertussis Vaccine, Combined (DTP).
2. Tetanus and Diphtheria Toxoids Combined, for adult use (Td).
3. Poliomyelitis Vaccine, Live, Oral, Trivalent (TOPV), human diploid cell origin.
4. Measles Vaccine, Live Virus, Further Attenuated, chick embryo origin.
5. Rubella Vaccine, Live Virus, Attenuated, duck embryo origin.
6. Measles and Rubella Vaccine, Live Virus, Attenuated, Combined (MR).
7. Mumps Vaccine, Live Virus, Attenuated, chick embryo origin.
8. Measles/Mumps/Rubella Vaccine, Live Virus, Attenuated, Combined (MMR).

B. ISDH SPECIAL STOCK or EMERGENCY ORDER, for "Special Use"
1. Rabies Vaccine, duck embryo origin (DEV).
2. Typhoid Vaccine.
3. Smallpox Vaccine, Live, vaccinia virus.

II. SERA, for PASSIVE IMMUNIZATION, by disease:

A. ISDH STOCK
1. Immune Serum Globulin, human origin (ISG, GG).
2. Rabies Immune Globulin, human origin (HRIG).
3. Snake Anti-Venin, Polyvalent Anticrotalid, equine origin.

B. BY SPECIAL ORDER AND EMERGENCY SHIPMENT
1. Vaccinia Immune Globulin, human origin (VIG).
2. Diphtheria Anti-Toxin, equine origin.
3. Botulism Anti-Toxin, Trivalent A,B.E. equine origin.

III. ANTIBIOTICS AND SUPPLEMENTS

A. FOR TREATMENT OF TUBERCULOSIS, STANDARD ISDH STOCK
1. Isoniazid (INH) tablets and syrup.
2. Para-Aminosalicylic Acid (PAS) tablets.
3. Para-Aminosalicylic Acid with ascorbic acid, combined (PAS-C) tablets.
4. Streptomycin (SM), injectable.
5. Ethambutol tablets (ETH).
6. Rifampicin capsules (RIF).
7. Pyridoxine tablets (Vitamin B6).

B. FOR TREATMENT of VENEREAL DISEASE
1. Penicillin G, Procaine, Aqueous, injectable (4cc in syringes, 600,000u/cc).
2. Ampicillin, 500 mg. capsules.
3. Probenecid, 500 mg. capsules.
4. Spectinomycin Injectable, 2 gram vials.
5. Tetracycline, 500 mg. capsules.
6. Benzathine, Penicillin G, injectable (4cc in syringes, 600,000u/cc).
7. Erythromycin, 250 mg. tablets.

IV. SKIN TEST DIAGNOSTIC ANTIGENS

A. TUBERCULIN, PURIFIED PROTEIN DERIVATIVE (PPD), Tween Stabilized.
B. HISTOPLASMIN.

BURN UNIT U. OF I.: FIRST FIVE YEARS

(Continued from page 101)

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Morbidity Report for January, 1976

Disease	Jan. 1976	1976 to Date	1975 to Date	Most January Cases Reported From These Counties
Adenovirus infection	1	1	1	Monona
Amebiasis	8	8	1	Boone, Johnson
Ascariasis	2	2	0	Johnson, Story
Blastomycosis	2	2	0	Clinton, Hardin
Brucellosis	2	2	1	Dubuque, Marshall
Chickenpox	1834	1834	1153	Dubuque, Lee, Pottawattamie
Conjunctivitis	110	110	123	Scattered
Encephalomyelitis	1	1	0	Black Hawk
Erythema infection	16	16	9	Howard, Marion, Page
Gastrointestinal viral inf.	3904	3904	4515	Bremer, Carroll, Chickasaw
Giardiasis	5	5	2	Chickasaw, Polk, Scott
Hepatitis, A (infectious)	8	8	15	Marion, Polk, Potawattamie
B (serum)	9	9	7	Scattered
type unspecified	3	3	0	Black Hawk, Guthrie, Linn
Histoplasmosis	2	2	3	Johnson
Impetigo	116	116	65	Lee, Polk
Infectious Mononucleosis	124	124	150	Johnson, Linn, Polk
Influenza-like illness	4728	4728	11761	Allamakee, Linn, Palo Alto, Polk
Influenza lab confirmed	14	14	70	Allamakee, Johnson
Leptospirosis	1	1	0	Linn
Meningitis *pneumococcal*	1	1	0	Linn
due to *Streptococcus agalactiae*	1	1	0	Polk
due to *E. coli*	1	1	0	Muscatine
due to *H. parainfluenzae*	1	1	1	Jasper
Meningococcal Meningitis	3	3	1	Cerro Gordo, Lee, Linn
Mumps	189	189	75	Scattered
Pasteurellosis	1	1	0	Polk
Pediculosis	54	54	42	Scattered
Pertussis	2	2	0	Polk, Woodbury
Pinworms	6	6	3	Linn, Polk
Pneumonia	79	79	151	Scott
Rabies in Animals	6	6	7	Calhoun, Cherokee, Howard
Rheumatic fever	2	2	2	Benton, Scott
Ringworm, body	43	43	26	Scattered
scalp	5	5	0	Cerro Gordo, Scott
Rubella	4	4	1	Bremer, Mills, Muscatine
Rubeola	13	13	0	Delaware, Dubuque
Salmonellosis	6	6	28	Polk
Scabies	92	92	31	Black Hawk, Polk
Shigellosis	4	4	7	Clayton
Streptococcal infections	1825	1825	1000	Scattered
Toxoplasmosis	1	1	0	Dallas
Trichinosis	51	51	0	Allamakee, Black Hawk, Clayton
Trichuriasis	1	1	0	Johnson
Tuberculosis, total ill	8	8	5	Scattered
bact. positive	8	8	4	Scattered
Venereal Diseases: Gonorrhea	704	704	126	Black Hawk, Linn, Polk, Scott
Syphilis	35	35	5	Cerro Gordo, Linn, Polk

Laboratory Virus Diagnosis Without Specified Clinical Syndrome Cytomegalovirus infection 5, Eaton's agent infection 5, Herpes simplex 10

Medical Assistants

by TENORA MEYER, CMA

STERILIZATION TECHNIQUES

Sterilization is an important task for the clinical medical assistant. With increasing numbers of patients and minor emergencies, it oftentimes requires much attention, organization and effort.

Patients need protection against the bacterial organisms all around us—in the air we breathe, objects we touch and substances which we ingest. Injections, surgical procedures, etc., can bypass the normal skin and mucous membrane defenses an individual possesses. Fortunately, we have available disposable syringes, needles, gloves, drapes and other materials which may be discarded after use, but materials used repeatedly which many patients can transmit infection or disease. We must therefore take appropriate measures to avoid contamination. Sanitation, disinfection and sterilization are the three principal methods of combating micro-organisms. Instruments should be cleansed in a detergent or blood solvent before sterilization. They should then be checked as to working condition before wrapping and placing in the autoclave. In the wrapping of instruments or supplies, clean muslin or disposable paper may be used because they can be penetrated by steam but not by surface or airborne contaminants during handling and storage. Hinged instruments such as hemostats must always be opened. If instruments must be used immediately, they may be sterilized in trays without individual wrapping. Clean muslin or similar material is placed over the bottom of the perforated tray, and the instruments are positioned neatly. The material is folded over the instruments and the tray is placed directly in the sterilizer. Materials should be properly positioned in the sterilizer so that all surfaces have contact with steam. They must be exposed to saturated steam at 250 degrees F. for 20 to 30 minutes. The materials must be allowed to dry before removal from the sterilizer. They should be stored in clean, dustproof areas where they can be considered to remain sterile for four weeks. All sterilized articles should be dated, checked periodically and resterilized when outdated.

Chemical sterilization may be used to sterilize heat-sensitive materials. These must be immersed according to the directions provided with the germicide being used and then should be rinsed in fresh isopropyl alcohol or sterile distilled water before use.

WHAT DO YOU DO?

If a patient asks to see his medical record, what do you do? This question was asked of clinic administrators across the country to determine how this kind of request is handled when such a demand could imply the possibility of a malpractice suit. With one exception, each clinic spokesman described a similar policy, despite different state laws governing accessibility to records. The general policy is that a conference be arranged between the attending physician, with record in hand, and the patient. Regardless of whether this practice is to avert malpractice actions, clinic administrators expressed the same concern—that the patient should be helped in every way to understand the treatment, diagnosis, or other cause for the inquiry. If the patient is insistent about obtaining a copy, the physician writes a summary and sends it to the patient at no charge. If the patient indicates a potential suit is the reason for the request, the complete record is sent to the patient's attorney after a release has been signed by the patient.—*These comments have been adapted from the Malpractice Digest, St. Paul Fire and Marine Ins. Co.*

About IOWA Physicians

Dr. Dennis O. Wright has joined the Sioux City Radiological Group. Dr. Wright received the M.D. degree at University of Nebraska School of Medicine in Omaha; interned at St. Benedict's Hospital, Ogden, Utah; and completed his residency in radiology at University of Washington in Seattle. . . . The following Webster City physicians are new officers of the Hamilton County Medical Society—**Dr. R. A. Patterson,** president; **Dr. E. F. Brown,** vice president; and **Dr. E. Reveiz,** secretary. . . . **Dr. James L. Knott,** Council Bluffs, has been elected 1976-1977 president of the Rotary Club of Council Bluffs. . . . **Dr. William J. Dall,** Dubuque, has been elected a member of American College of Physicians. . . . **Dr. Ron Flory** resumed his family practice in Grundy Center in January. Dr. Flory joined **Dr. Patricia Ehrich** at the Grundy Family Clinic in July, 1973, but two months later was called to duty by the U. S. Air Force. Dr. Flory, a graduate of U. of I. College of Medicine, was in Family Practice Residency at Broadlawns Hospital in Des Moines prior to locating in Grundy Center.

Dr. John Ahrens was guest speaker at recent meeting of Oelwein Rotary Club. Dr. Ahrens spoke on cancer. . . . **Dr. P. J. Leehey** has been reappointed chief of staff at People's Memorial Hospital; **Dr. Richard Myers** was renamed vice chief of staff and **Dr. John Mochal,** secretary. All are Independence physicians. . . . **Dr. John Doran,** Ames; **Dr. Herbert Gude,** Iowa Falls; **Dr. Robert Schafermeyer,** Eldora; **Dr. Thomas McGarvey,** Waterloo; and **Dr. Robert Guthrie,** Waterloo, participated in a "Cancer Workshop" at Iowa Falls sponsored by Ellsworth Community College and American Cancer Society. . . . **Dr. John J. Finneran** has been elected president of Davis County Medical Society; **Dr. James R. Mincks,** vice president; **Dr. John R. Schiebe,** secretary, **Dr. Henry M. Perry,** delegate; and **Dr. Philip Caster,** alternate delegate. All are Bloomfield physicians. . . . **Dr. H. H. Gessford,** retiring George physician, was recently honored by the local chamber of commerce for his 27 years of medical service in the area. . . . The following Sioux City physicians are 1976 officers of Sioux City's St. Vincent Hospital medical staff—**Dr. Vernon Helt,** president; **Dr. George Spellman,** vice president; and **Dr. Sidney E. Cohen,** secretary-treasurer. . . . **Dr. James F. Bishop,** Davenport, president-elect of the Iowa Medical Society, was guest speaker at recent meeting of the Woodbury Medical Society.

Dr. P. A. McLaughlin has been re-elected president of Mercy Hospital medical staff in Iowa City. **Dr. R. D. Whinery** was named president-elect; and **Dr. A. R. Sherburne,** secretary-treasurer. All are Iowa City doctors. . . . **Dr. F. H. McClurg,** Fairfield, was honored at annual meeting of Jefferson County Medical Society. Dr. McClurg, who retired in December, was presented a bronze plaque with an engraving of one of his early prescription forms. The plaque also contained the signatures of his medical associates. . . . **Dr. John Puk** has been named president of Mercy Hospital medical staff in Cedar Rapids; **Dr. Joseph F. Galles,** vice president and **Dr. Dale Roberson,** secretary-treasurer. All are CR physicians. . . . **Dr. E. J. Steenrod,** Iowa Falls, retired January 31. Dr. Steenrod came to Iowa Falls in 1939. A graduate of University of Pittsburgh School of Medicine, Dr. Steenrod interned at West Penn Hospital in Pittsburgh and completed his surgery residency at Mayo Clinic, Rochester, Minnesota. . . . **Dr. M. B. Croxdale** has been elected president of Davis County Hospital staff; **Dr. Philip Caster,** vice president and **Dr. Dennis Keithly,** secretary. All are Bloomfield physicians. . . . **Dr. Donald Faber,** LeMars, has been named chief of staff at

Floyd Valley Hospital; **Dr. L. A. George,** Remsen, vice president; and **Dr. S. E. Lindell,** LeMars, secretary.

Dr. James L. Flood, Denison, has been elected president of Crawford County Memorial Hospital staff; **Dr. D. N. Crabb,** Denison, vice president; and **Dr. M. U. Broers,** Schleswig, secretary. . . . **Dr. Mahendra S. Shah,** urologist, will join the Gilfillan Clinic in Bloomfield in February. A native of India, Dr. Shah received the M.D. degree from the Medical College of Baroda; interned at Queens Hospital in New York City; and completed his residency in surgery at the VA Hospital in Bronx, New York. His sub-specialty training in urology was completed at Cook County Hospital in Chicago; the New Rochelle Hospital Medical Center in Manhattan, New York; and Wilmington Medical Center in Wilmington, Delaware. . . . At annual meeting of Wright County Medical Society, **Dr. G. B. Hogenson,** Eagle Grove, was re-elected president; **Dr. R. F. McCool,** Clarion, vice president; **Dr. C. P. Hawkins,** Clarion, secretary-treasurer; **Dr. A. F. Benetti,** Belmond, delegate; and **Dr. R. A. Young,** Clarion, alternate delegate.

Dr. Robert E. Fellows will become head of the U. of I. Department of Physiology and Biophysics July 1. Dr. Fellows earned A.B., M.D., and Ph.D. degrees at Hamilton College, McGill and Duke Universities, respectively; had an internship and residency in internal medicine at the New York Hospital, and a second residency at Royal Victoria Hospital in Montreal. He has been on the faculty at Duke University since 1966. . . . **Dr. Robert Bremner,** Cedar Falls, was guest speaker at recent meeting of the Iowa City Christian Women's Club. . . . **Dr. F. B. Leffert,** Centerville, describes his life in a book entitled, "Life and Medical Practice of a Country Lad." Dr. Leffert is a life member of the Iowa Medical Society. . . . **Drs. Oliver Stoutland, Gary Lawrence** and **Donald Boldt,** of the Ackley Medical Center and the Ellsworth Municipal Hospital in Iowa Falls, are featured in a film, "The New Country Doctor," recently produced by the Iowa Regional Medical Program at the University of Iowa. The physicians tell the advantages of their three-man family practice.

Dr. Martha Capizzi opened a family practice in Glenwood in February. A native of Mexico, Dr. Capizzi recently completed three and one-half years of family practice training at U. of I. College of Medicine. . . . **Dr. Hunter H. Comly,** former professor of child psychiatry at the U. of I., is new chief of the Child Psychiatry Division at Linn County Psychiatric Clinic in Cedar Repids. . . . **Dr. Azmy R. Bowtros,** professor in Department of Anesthesiology at U. of I. College of Medicine, spoke on "Intensive Care for Small Hospitals" at Veterans Memorial Hospital in Waukon. The program was sponsored by the Minowa Area Health Planning Council. . . . The following Sioux City physicians participated in Second Annual Perinatal Care Program in Sioux City—**Dr. L. W. Van Voorhis; Dr. Richard Ratino; Dr. James Boysen; Dr. William Jackson;** and **Dr. Olaf Selander.** U. of I. College of Medicine faculty participants were—**Dr. Allen Erenberg;** neonatologist and assistant professor of pediatrics; **Dr. Herman Hein,** director for Statewide Perinatal Care Program and assistant professor of pediatrics; **Dr. Ray Sturdevant,** resident in department of pediatrics; and **Dr. Frank Zlatnik,** assistant professor of obstetrics and gynecology. The event was sponsored by St. Luke's Medical Center and the Statewide Perinatal Care Program.

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Dr. Owen Frank, Maquoketa physician for 57 years, retired January 1. Dr. Frank began his practice in Maquoketa following graduation from U. of I. College of Medicine in 1919. . . . **Dr. Walter A. Anneberg** ended 52 years of medical practice in Carroll in January. Dr. Anneberg received the M.D. degree at U. of I. College of Medicine in 1923. Dr. Anneberg is a founding fellow of the American College of Obstetrics and Gynecology; past president of Carroll County Medical Society; and past chief of staff at St. Anthony's Hospital in Carroll. He plans to spend part of his retirement at his Lake Okoboji cottage. . . . **Dr. Oscar H. Banton,** Charles City, was recently honored at an open house in celebration of his 90th birthday. Dr. Banton is a life member of the IMS. . . . **Dr. James Habermann,** Fort Dodge, was guest speaker at January meeting of the Wright County Medical Society.

Dr. Robert Guthrie, Waterloo, spoke on "Women's Health, Breast Cancer" at a public meeting in Independence sponsored by People's Memorial Hospital Auxiliary, Buchanan County Farm Bureau and American Cancer Society. . . . **Dr. Donald C. Young** has been installed president of the Polk County Medical Society. Other new officers include Dr. Wendell K. Downing, president-elect, and Dr. Donna Drees, secretary-treasurer. All are Des Moines physicians. . . . **Dr. William C. Rosenfeld,** Mason City, has been elected a director of the American State Bank. Dr. Rosenfeld is a partner in Internal Medicine Associates and immediate past president of the Mercy Hospital medical staff. **Dr. Kingsley B. Grant,** Cedar Rapids, has assumed directorship of the Department of Pathology and Laboratory Services at St. Luke's Methodist Hospital. Dr. Grant is also chief of pathology at St. Luke's and a clinical assistant professor of pathology at U. of I. College of Medicine.

Dr. R. G. Vernon has been elected president of Dubuque County Medical Society. Other officers are—**Dr. T. J. Benda,** president-elect; **Dr. D. L. Kayle,** secretary; and **Dr. R. A. Madden,** treasurer. All are Dubuque physicians. . . . **Dr. Sherman Lindell,** LeMars, is serving as physician for infirmary patients at Cherokee Mental Health Institute. Dr. Lindell has practiced in LeMars since 1954. . . . **Dr. James Asher** will join **Dr. Joseph Rooney** in Algona in family practice October 1. Dr. Asher is a graduate of the University of Nebraska School of Medicine and is completing a three-year family practice residency. . . . **Dr. George H. West,** Mason City, is new president of Cerro Gordo County Medical Society. Other Mason City physicians elected: **Dr. Robert M. Powell,** vice president; **Dr. J. D. Thoreson,** treasurer; and **Dr. R. Bruce Trimble,** secretary. . . . **Dr. Warren Bowers,** Grinnell, was guest speaker at annual meeting of Grinnell General Hospital Auxiliary. . . . **Dr. Jack L. Crain** has joined **Drs. Don O. Newland** and **Norman L. Bone** in practice of obstetrics and gynecology in Des Moines. Dr. Crain was formerly associated with **Dr. David Wetrick** in Ottumwa. . . . **Dr. Louis H. Fingerman,** Des Moines, spoke at recent meeting of Central Iowa Association of Industrial Nurses.

PLAN REHAB SEMINAR

The 14th Annual Orthopaedic and Rehabilitation Seminar presented by the Younker Memorial Rehabilitation Center will be April 9 and 10 at the Des Moines Hyatt House. The session will convene at 1 p.m. April 9 and adjourn at 4 p.m., April 10.

Speakers will include Paul R. Meyer, Jr., M.D., associate professor of orthopedic surgery, Northwestern University; Ernest Johnson, M.D., chairman, Department of Physical Medicine and Rehabilitation, Ohio State University; William E. Knight, M.D., Holt-Krock Clinic, Fort Smith, Arkansas; Mercer Rang, M.B.B.S., Toronto, Ontario, Canada; Albert B. Ferguson, Jr., M.D., professor of orthopaedic surgery, University of Pittsburgh; Ronald L. Linscheid, M.D., associate professor, Mayo Medical School, and W. J. Robb, M.D., Cedar Rapids.

The program has been arranged by John H. Kelley, M.D., Department of Orthopaedic Surgery, and William D. deGravelles, Jr., M.D., Department of Physical Medicine and Rehabilitation, Younker Memorial Rehabilitation Center, Iowa Methodist Medical Center. The meeting is co-sponsored by the Iowa Orthopaedic Society and is acceptable for 9 hours of credit by the American Academy of Family Physicians.

DEATHS

Dr. Clarence E. Broderick, 82, Cherokee, died January 20 at his home. A 1918 graduate of U. of I. College of Medicine, Dr. Broderick began his practice in Newton. In 1925, following a year of study in eye, ear, nose and throat specialty at University of Vienna in Austria, Dr. Broderick established a medical practice in Cherokee. He retired in 1967. Dr. Broderick was a 50-year member of the American Legion and a life member of the Iowa Medical Society.

Dr. George W. Egermayer, 87, retired Elliott physician, died January 21 at Murphy Memorial Hospital in Red Oak. Dr. Egermayer received the M.D. degree at University of Illinois Medical School and established his medical practice in Elliott in 1934, retiring in 1958.

Dr. R. L. Baltzell, 43, former Anthon physician, was killed in a car-motorcycle accident near Brownsville, Texas, January 30. Dr. Baltzell received the M.D. degree at University of Pennsylvania Medical School. He began his medical career in Anthon in 1960, following completion of his internship at University of Colorado. In mid-December 1975, Dr. Baltzell moved from Anthon to Brownsville, Texas, where he was associated with the Rancho Viejo Medical Clinic.

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FAMILY PRACTITIONER seeks **FAMILY PRACTITIONER** to cover his practice for one year as soon as available. Salary $40,000 yearly. Week-end and vacation coverage available. Practice located in northeast Iowa. Address your inquiries to Rural Family Practice Clinic, P.C. W. H. Verduyn, M.D., 514 Main, Reinbeck, Iowa 50669.

PSYCHIATRIC RESIDENCY—Vacancies for positions for those who have a regular Iowa license or can obtain one by reciprocity or via the FLEX. Prepare for career in private practice, community clinics or hospital based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, Children's Unit, Adolescent Unit. Neurology affiliation with University of Iowa. The stipends are: 1st year, $20,280; 2nd year, $21,294; 3rd year, $22,360. Intensity and diversity of training program appreciated best by personal visit. Superintendent, Mental Health Institute, Cherokee, Iowa 51012. Equal Opportunity Employer. Call Collect 712/225-2594.

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OB-GYN, UROLOGIST, ORTHOPEDIC SURGEON wanted to join established 16-man multispecialty group in Central Iowa. Immediate financial partnership. Outstanding fringe benefits. Regional hospital, excellent schools, recreational facilities. Write No. 1512, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

WANTED—ANESTHESIOLOGIST with interest in family practice, **GENERAL INTERNIST** and **FAMILY PRACTITIONER** to join 11-man professional corporation. Lucrative financial package, excellent fringes, great recreational facilities and a good place to raise a family. Hospital is seven years old, progressive and expanding. Contact M. Brentnall, CPA, Creston Medical Clinic, P. C., 526 New York Avenue, Creston, Iowa 50801.

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March 3	Diet Therapy U.S.A.
March 10	Managing Common Skin Problems
March 11	Vision Workshop for the Family Physician
March 29-April 1	Cardiology Today
April 5-9	Intensive Course in Pediatric Nutrition
April 6-8	Iowa Medical Society Scientific Meeting
April 7	Ophthalmology Clinical Conference
April 10-11	Midwest Residents in Anesthesiology
April 20-24	Course and Workshop on Echo-Ophthalmography
April 24-25	Eye Enucleation Course
April 29-30	Recent Advances in Reproductive Immunology

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ring age, weigh potential benefit
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tropics or anticonvulsants, consider
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action. Usual precautions indicated in
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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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President's Page

The Annual Meeting of the Iowa Medical Society House of Delegates will be May 1 and 2 in Des Moines. As a Society member, you are welcome to attend these sessions; your IMS officers urge you to do so.

Too often it's assumed meetings of the House are only for the delegates. This is far from the truth. The delegates need your thoughts so they can properly represent you and your constituent county society.

At the open hearings of the reference committees (the afternoon of May 1) ample opportunity will be allowed for the presentation of comment and opinion from interested physicians on those subjects before the House. It is from this debate in the reference committee hearings that the ultimate recommendations emerge; these are accepted, rejected or modified by the House at the concluding session.

Resolutions are now being received and reports are being filed. Acquaint yourself with these. It's easy to stay home and criticize the actions of others—when the place to be heard is really the reference committee hearings.

The delegates from the counties establish IMS policy through their actions on resolutions and reports. The Society officers carry out these policies. The delegates set the Society dues based on recommendations from the Board of Trustees. The Board prepares the budget and maintains surveillance over it during the course of the year.

Plan to attend the 1976 sessions of the Society's House of Delegates. You'll find it an interesting experience.

Sincerely,

V. L. Schlaser MD

V. L. Schlaser, President

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UNIVERSITY ISSUE

This is the sixth occasion on which I have been privileged to introduce the University Issue of the JOURNAL to you in my capacity as dean, and to express my gratitude, and that of my colleagues, to the Iowa Medical Society for thus opening its publication's pages so generously to the College of Medicine.

This cooperative gesture is yet another reminder of the College's good fortune in having such a close working relationship with our professional society, whose collective strength has been a potent force in building and maintaining public support for medical education in this state, and whose individual members provide a great deal of ongoing guidance to the educational effort itself.

Because of the interest which so many of you demonstrate so tangibly in the work of the College of Medicine, I thought I might report this year on several areas in which we are making headway, while noting several other areas of concern to us. These appear on the following pages in no particular sequence or order of priority.

This year's University Issue also features an up-to-date profile of the University of Iowa Hospitals and Clinics, provided by Director John W. Colloton, which you will find to be both interesting and informative.
—JOHN W. ECKSTEIN, M.D., *Dean, College of Medicine*

Some Measures of Medical Education

JOHN W. ECKSTEIN, M.D.
Iowa City

Assessing the quality of a medical school calls for a close look at its students, teachers, facilities—and approach. Here are some of the factors on which the College of Medicine can be judged in 1976.

REGARDLESS OF what his or her alma mater, the practitioner who has been out of medical school for a decade or more will find many changes upon return to the campus. At Iowa, the most noticeable differences would be the scale and pace. To maintain and improve quality is the primary challenge facing faculty and administrators—especially in a time of vacillating national policy on support for medical education.

CONCERNING STUDENTS

With its freshman class stabilized at 175 these past three years, the College of Medicine might be expected to have an enrollment approximately four times that number. But in fact the instruction which the College provides to students in a wide variety of health professions would, if converted to medical student class load, be equivalent to a freshman medical class more than *10 times* that size—1,795 students in 1974-75, with this year's total expected to be somewhat higher when all the registrations are counted.

Undergraduate medical students themselves last year numbered 663. In addition, 409 residents and interns, 271 graduate students, and some 6,750 continuing education enrollees received instruction from College of Medicine faculty members this past year.

So did another 2,700-plus non-medical students: 187 from Dentistry, 331 from Pharmacy, 79 from Nursing, 36 from the Physician's Assistant program, 237 from other allied medical programs, and 1,836 from the College of Liberal Arts, where they are enrolled in a variety of undergraduate arts and science majors. This last component continues to increase with the growing interest in ecological and environment studies.

In all, College of Medicine faculty members shared their knowledge last year with some *10,800* students ranging in age and experience from first-day freshmen to senior practitioners in a variety of fields.

Elsewhere in the JOURNAL Mr. Taylor reports on the academic qualifications and extracurricular interests of this year's freshmen. In view of the quality of these young people and their fellow undergraduates, we are finding it painful to have to tell increasing numbers of them that we cannot provide financial help to the extent that many of them need it today.

On the basis of comprehensive interviews with the College of Medicine's fiscal aid officer, records of parental income and other information, 284 medical students have a documented need for $1,088,367 in student aid funds this year. Loans totaling $578,451 and scholarships totaling $152,647 still leave more than a third of a million dollars—35 percent of these students' total need—unmet from any source controlled in any way by the University. Most of the fund shortage

Dr. Eckstein is Dean of The University of Iowa College of Medicine.

stems from the federal government's reduced contribution to the Health Professions Loan program.

FACULTY

Exceptionally heavy demands continue to be made upon the scientists and physicians who comprise the College of Medicine faculty.

Not only are they responsible for guiding a sizeably increased student body through a curriculum which is much more demanding of faculty time than were previous curricula, but they must also cope with changing patterns of patient care which exact progressively greater tolls in time and effort.

The College of Medicine's clinical faculty is responsible for patient care at University Hospitals and Clinics, and at the Veterans Administration Hospital. On any given day there are about 1,400 bed patients in these two facilities, and from 1,000 to 1,500 in the outpatient clinics. From one-fourth to one-third of the University Hospitals patients are indigent, and faculty members annually contribute the equivalent of $5 million in non-reimbursed services to these individuals.

Under the Medical Service Plan adopted at Iowa 30 years ago this Fall (and since then widely copied throughout the country), clinical members of the College of Medicine faculty agree to turn over their patient care earnings to their departments, where these funds are re-allocated for educational purposes. Some $100 million has been "plowed back" into the educational program from this source since 1946.

Some sense of the quality of today's faculty is provided by the fact that 25 currently serve on various federal review panels and boards; others hold 401 offices or key committee appointments in non-governmental national bodies including their specialty Boards and residency review committees, and 15 are advisors to Iowa state government agencies. During the current academic year 17 College of Medicine faculty members received NIH Research Career Development Awards—the third highest total among Big Ten Universities.

College of Medicine faculty members are active participants in the affairs of organized medicine, in Iowa and elsewhere. More than 200 of the clinical faculty are members of the Iowa Medical Society, with two having served as president of the Society within the past 16 years. Faculty members are serving on 30 IMS committees this year. Two are members of the AMA House of Delegates.

I can hardly over-emphasize the high quality of today's medical faculty, whose members are truly "triple-threat" professionals: imaginative and innovative teachers; persistent and perceptive researchers; and skilled clinicians with extraordinary ability to communicate their work and ideas to others. Other institutions recognize these abilities, too, and make many overtures towards them with the hope of enticing them away from Iowa.

Stepping down this year from positions of departmental leadership are two individuals well known as teachers, friends and colleagues by many IMS members: Professors James Clifton, head of Internal Medicine; and Carl Vestling, Biochemistry. Search committees are actively seeking their replacements, whom we expect to have on hand to greet the Class of 1980 by the opening of classes this Fall.

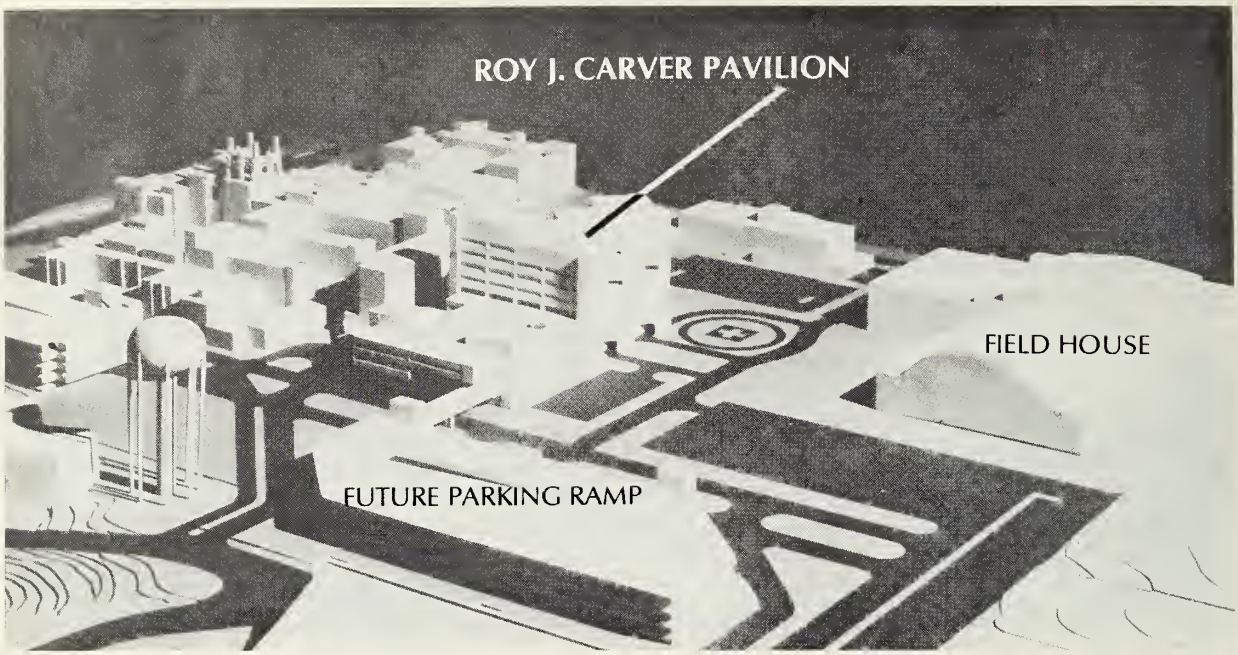
Dr. Robert Fellows, now on the physiology and internal medicine faculties at Duke University, will come to Iowa this summer to head the Department of Physiology and Biophysics. Following graduation from McGill he took internal medicine residencies at The New York Hospital and Royal Victoria Hospital in Montreal, before earning his Ph.D. at Duke.

THE EDUCATIONAL EFFORT

Today's medical students begin early to focus on the medical practice elements of the curriculum, learning the skills of dealing with patients and how to recognize the variety of factors that may be involved in a health problem.

In the first three semesters of basic science study, many components are taught from a patient problem perspective, and various electives provide practical clinical experience. The fourth semester is given entirely to an intensive course entitled Introduction to Clinical Medicine. Here students focus specifically on the knowledge, skills and attitudes that bridge the basic sciences and the clinical rotations.

The third year includes 11 months of core clinical education where each student works and studies in the traditional clerkship setting. Much attention is given to evaluation and reinforcement of the students' individual needs. The final year of study is "tailored" by each student and his or her advisor to provide emphasis as needed



GROWTH PICTURE—This architect's model shows Phase II of the Capital Development Program at University of Iowa Hospitals and Clinics. Roy J. Carver Pavilion and a 700-stall parking ramp will be completed in 1977.

and desired in relation to the student's career choice.

Early and continued emphasis on encouraging students to get part of their training in a community setting is contributing to the steady increase in the numbers of students electing careers in primary care disciplines. Freshman medical students wishing to gain "real-life" medical experience very early in their academic careers are invited to take part in the Medical Education-Community Orientation (MECO) program sponsored jointly by IMS, Iowa Hospital Association, Student American Medical Association and the College of Medicine. The junior preceptorships cited by Dr. Caplan elsewhere in this issue, and the off-campus elective hours being taken by 90% of the seniors, provide many opportunities for these young people to experience for themselves the satisfactions of community practice. Seniors are spending 25% of their time in such "remote site" training. With three-fourths of all such experience being gained in the primary care disciplines, it is not surprising that 77% of the new graduates are going on to primary care residencies, one-third of them in Iowa.

To help faculty members improve their teaching skills, and to aid student learning, the College of Medicine's Learning Resources Center provides a variety of services. Educational consultants advise on testing, objectives, learning strategies and research on both teaching and learning. Learning Resources staff members plan and conduct conferences, workshops and seminars on educational topics for faculty, and assist individual faculty members in developing alternative and innovative teaching techniques—the "professional patient," for instance, who is trained to recognize the fine points of history-taking and physical examinations and can assist the teacher by articulate responses to the student, and the use of videotape monitoring of early student efforts at history-taking and physical examinations.

While such techniques as simulation and computer feedback seem unlikely ever to replace completely the lecture and the one-to-one demonstration, and while some teachers will always be more highly regarded than others, learning has nevertheless become both more interesting and more effective than it used to be.

FINANCIAL CONCERNS

Faithful readers of the JOURNAL may recall that I dwelt last year at some length in these pages concerning the extent to which the federal government is withdrawing support from medical education programs for which it had provided

strong and tangible encouragement only a few years earlier.

Federal support continues to deteriorate, notwithstanding a considerable effort by University and state officials to impress upon the Congress and the Administration what this is doing to education—and at a time when we are being called upon to provide more practitioners generally, to meet the needs of under-served areas, and to prepare for continued increases in the demands for medical services.

Fortunately, the State Board of Regents, the General Assembly, and Governor Ray have perceived the scope of the problem, and have sought to provide state dollars to replace some of the federal dollars no longer available for medical education. By the end of the current fiscal year June 30, the College of Medicine will have "drawn down" a total of $1,782,278 from this source since mid-1974, to continue partial support for various educational—not research—programs whose loss would seriously weaken the College's teaching capability.

We are grateful to Iowa Medical Society members who have urged legislators to support these "makeup" appropriations, and for the special efforts made in this area by members of the Iowa Academy of Family Practice, which organization sponsored a special mailing last Spring of my explanation of the federal fund loss problem.

During the current fiscal year we anticipate the loss of $1,453,295 federal dollars from our teaching budget. The extent to which we shall be able to replace these from state appropriations is not yet known, the legislature still having the question under consideration as I write this.

In the current College of Medicine budget, 36.5% ($15.7 million) comes from federal funds. The next largest increment, 29.9% ($12.9 million) is derived from fees earned by faculty members for patient services rendered in University Hospitals and Clinics. The University's General Fund provides 25.9% or $11.1 million, with $7.8 million of this sum representing tax appropriations (the rest being derived from student tuition and recovery of indirect costs related to research). The budget's final $3.3 million increment (7.7%) is derived from non-federal grants and gifts.

Another relative measure of the extent to which we depend on faculty to finance their own teaching efforts is revealed by JAMA's special "Education Number," published last December. It reported that nationally the percentage of financial support provided medical colleges from faculty earnings "grew from seven to eight percent in fiscal 1974." *At Iowa,* as noted above, *that portion was almost 30 percent.*

MEASURES OF QUALITY

In judging the worth of a medical school, the elusive factor of quality defies precise quantification, just as it does elsewhere.

Yet there are several elements and standards of performance which, if present and met, can be accepted as indications of a quality program in medical education.

These would include a faculty whose members are clearly qualified to teach and demonstrate; students who are among the brightest, best-prepared members of their generation; physical facilities which enhance rather than inhibit learning; a positive program which creates and sustains a supportive atmosphere; and stability of support.

These elements are demonstrably present at Iowa, as has been suggested or documented in the preceding sections of this report. Several additional observations are also relevant at this point.

Notwithstanding the problems created by changes in objective and direction of several federal programs, the College of Medicine has for some years enjoyed a generally stable degree of support. More than anything else, this reflects concern, understanding and effort on the part of the State Board of Regents, the General Assembly, the Governor and the University administration, all of whom have expressed determination that medical education be strengthened in this state.

Another fundamental and critical element of medical education here is the outstanding University Hospitals and Clinics, one of the finest teaching hospital organizations in the country in which to learn the vital elements of patient care. The Veterans Administration Hospital, right here on the campus, provides many other important learning opportunities for Iowa medical students.

A well-timed building program which gave us the new Basic Sciences Building, the Health Sciences Library, and several major additions to the hospitals and clinics, has also contributed substantially to the quality of instruction. Older facilities such as the Medical Laboratories Building can be renovated and modernized at relative-

ly small cost as remodeling funds become available to the College.

In its recently published "Institutional Profile Ranking Report," the Association of American Medical Colleges noted that, out of 109 medical schools, The University of Iowa College of Medicine ranked as follows in the period studied:

Fourteenth in the number of undergraduate medical students enrolled but seventh in the total number of all students taught by faculty in the College; twenty-fourth in both the total number of full-time faculty members and the number of full-time faculty in the basic sciences.

First in the total revenues received from professional fees under the Medical Service Plan and second in the share of the medical school operating budget supported from this source; twenty-third in average salaries paid to full-time clinical faculty; twenty-second in the number of M.D. alumni; and twenty-fourth in the number of alumni in the primary care disciplines.

While it by no means solves the problem of support for the teaching program, College of Medicine income from research grants is "holding its own" at a time when other medical schools are experiencing a decline in revenue from this source—further proof of the high quality of the Iowa medical faculty. Research grants from federal agencies—primarily the National Institutes of Health—have brought an average of $12 million to the College in each of these past several years.

In point of fact, The University of Iowa ranked 32nd among the nation's top 100 universities in the amount of grants received from all federal agencies during 1974-75. While other U of I colleges were involved in these over-all statistics, the College of Medicine was responsible for the major share of the awards.

American medical schools today range from institutions so new that their first classes are still in the academic pipeline, to schools whose beginnings—and generous endowments—go far back into the 19th Century. As with many other state-supported medical schools, most of The University of Iowa College of Medicine's growth has occurred in the post-World War II years, when federal support provided the first real opportunity for education and research on a major scale. Thus, Iowa is still in its youth as a major institution.

Graduates of the College of Medicine continue to get the residencies they want, to locate where they choose, and to practice or teach with the best of their peers. And this, I submit, is the most meaningful measure of quality of their educational environment.

A FINAL OBSERVATION

Most of our efforts are necessarily oriented toward maintaining and enhancing quality and stability in the educational programs. In striving to achieve these goals, we begin by exercising great care in selecting faculty who can challenge the bright young minds whom we seek as students and future physicians. The market for such teachers remains unbelievably competitive.

Iowa medical students are exposed to a wide range of professional services in a regional tertiary-care center which is itself in a continuous state of forward motion, updating its patient care facilities and adding to its resources.

As we move into the last quartile of the 20th Century, the College of Medicine expects to continue to innovate and strengthen, while avoiding dilution of quality through the fragmentation which can so easily result from inflation, instability of the times, and various social pressures.

The College of Medicine's mission remains as clear in its 106th year as it has been from the beginning: to produce first-class physicians and other health professionals. To this we are committed without qualification.

CONTINUING EDUCATION COURSES & CONFERENCES

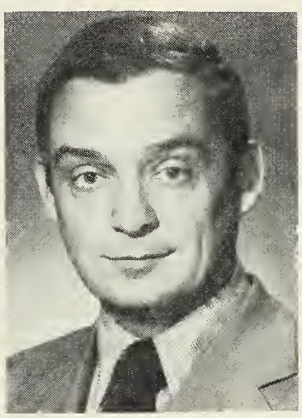
Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

April 5-9	Intensive Course in Pediatric Nutrition	April 20-24	Course and Workshop on Echo-Ophthalmography
April 6-8	Iowa Medical Society Scientific Meeting	April 24-25	Eye Enucleation Course
April 7	Ophthalmology Clinical Conference		
April 10-11	Midwest Residents in Anesthesiology	April 29-30	Recent Advances in Reproductive Immunology

The largest university-owned teaching hospital has 2,000 patients a day. They're cared for by 787 doctors and 2,500 hospital support staff. And in it all are 1,100 health science students.

A Profile of The University of Iowa Hospitals and Clinics

JOHN W. COLLOTON
Iowa City



THE SIZE of the University of Iowa Hospitals in relation to the country's other 58 university-owned teaching hospitals has been a matter of some speculation for many years. The facts are it is the largest university-owned teaching hospital in the country at this time! This assertion is based on a study by the National Council on Teaching Hospitals of the American Association of Medical Colleges in 1973. The study encompassed the nation's 59 university-owned teaching hospitals, constituted of all of the west coast teaching hospitals, including the University of California group, Stanford, University of Washington and others; all of the Big Ten schools; all of the southern teaching hospitals, such as Duke, Vanderbilt, Alabama, and, of course, the east coast medical centers in upstate and downstate New York as well as New York University Hospital. (See Tables I, II, III on the next page.)

The 60-page study covered a number of parameters including the conventional hospital indices (as shown in accompanying illustrations): number of beds, number of patient admissions, patient days of service rendered. By all of these measures, the University Hospitals are one of the largest in the nation.

How did University Hospitals achieve its present status.

A UNIQUE EXPERIMENT

University Hospitals had its genesis in 1898 on the east campus in what is now East Hall. A major thrust came in 1919 with the passage of the Haskell-Klaus Act by the Iowa legislature. That legislation recognized the state's responsibility for care of indigent patients and coupled this responsibility with the state's medical education program and a state transportation system all financed through a direct appropriation to University Hospitals.

This act represented a unique experiment in health care delivery. It was brought to fruition with a $2 million state appropriation which, when matched by the Rockefeller Foundation, permitted construction of a 900-bed University General Hospital which is still the nucleus of our operation today.

In 47 years University Hospitals has provided care to nearly one million individual patients. Of this total, approximately 80% or 800,000 patients have been Iowans—this number representing 517,000 different Iowa family units. Our statisticians have recently determined Iowa has had one

Mr. Colloton is Director of University of Iowa Hospitals and Clinics and Assistant Executive Vice President for Health Services. This paper has been adapted by the Hospital's public information service from a speech given by Mr. Colloton to the Iowa City Rotary Club.

TABLE I

NUMBER OF BEDS
1973

University of Iowa Hospitals and Clinics	1,092
University of Texas Medical Branch Hospitals	1,089
University of Michigan Hospitals	1,030
Medical College of Virginia Hospital, Virginia Commonwealth University	995
Ohio State University Hospitals	976
Hospital of the University of Pennsylvania	862
University of Minnesota Hospitals	832
Duke University Hospital	796
New York University Medical Center	782
Thomas Jefferson University Hospital	736

Source: Department of Teaching Hospitals, Association of American Medical Colleges.

TABLE II

PATIENT DAYS OF SERVICE
1973

University of Iowa Hospitals and Clinics	310,250
University of Texas Medical Branch Hospital	307,695
University of Michigan Hospitals	271,560
Ohio State University Hospitals	267,545
Hospital of the University of Pennsylvania	259,150
Medical College of Virginia Hospital	258,420
New York University Medical Center	254,405
Duke University Hospital	242,725
University of Minnesota Hospitals	219,730
Strong Memorial Hospital (University of Rochester)	215,350

Source: Department of Teaching Hospitals, American Association of Medical Colleges.

million family units in the past 47 years, meaning that University Hospitals has served one of every two Iowa family units during the past four decades.

Total units of service over this 47-year period include 1,050,000 patient admissions to the hospital and 7,300,000 ambulatory patient visits to our specialty diagnostic clinics. In the same time period, more than 70,000 Iowans have been born at the University Hospitals.

Our 17-unit ambulance fleet was established in 1932 and has traveled more than 57 million miles on Iowa highways, transporting 395,000 patients from their homes to University Hospitals and back again.

EXPERIMENT RESULTS

The success of the experiment initiated by the Iowa General Assembly in the early 1900's is reflected in the following growth statistics on University Hospitals:

a) Admissions growth from 16,000 in 1946 to 36,000 in 1974 (109.5% increase).

b) Ambulatory patient visits to diagnostic clinics from 170,000 in 1959-60 to 288,178 visits in 1974 (5% growth per annum).

c) A county-by-county analysis of admissions shows 90% of University Hospitals' patients are Iowans and 90% come to the Hospitals from outside Johnson County, indicating heavy statewide utilization.

d) Twenty-seven health science education programs have a current enrollment of 1,740 students. They represent all disciplines of medicine, dentistry, pharmacy, nursing, and the allied health professions.

e) House Staff programs devoted to specialty training in medicine and dentistry have grown at an annual rate of 7% in recent years, increasing from 246 trainees in 1965 to 469 today.

f) To serve the increasing number of patients, the Hospitals' professional staff has been increased by 262% since 1950. Specific staff categories and corresponding growths are shown in the accompanying graph. The Hospitals' aggregate staff, including both professional and supporting staff, has increased by 145% since 1950.

This growth has resulted in University Hospitals becoming a regional referral center, with a full spectrum of primary, secondary and tertiary clinical services. There is an increasing emphasis on the tertiary, or top level, at the present time.

TABLE III

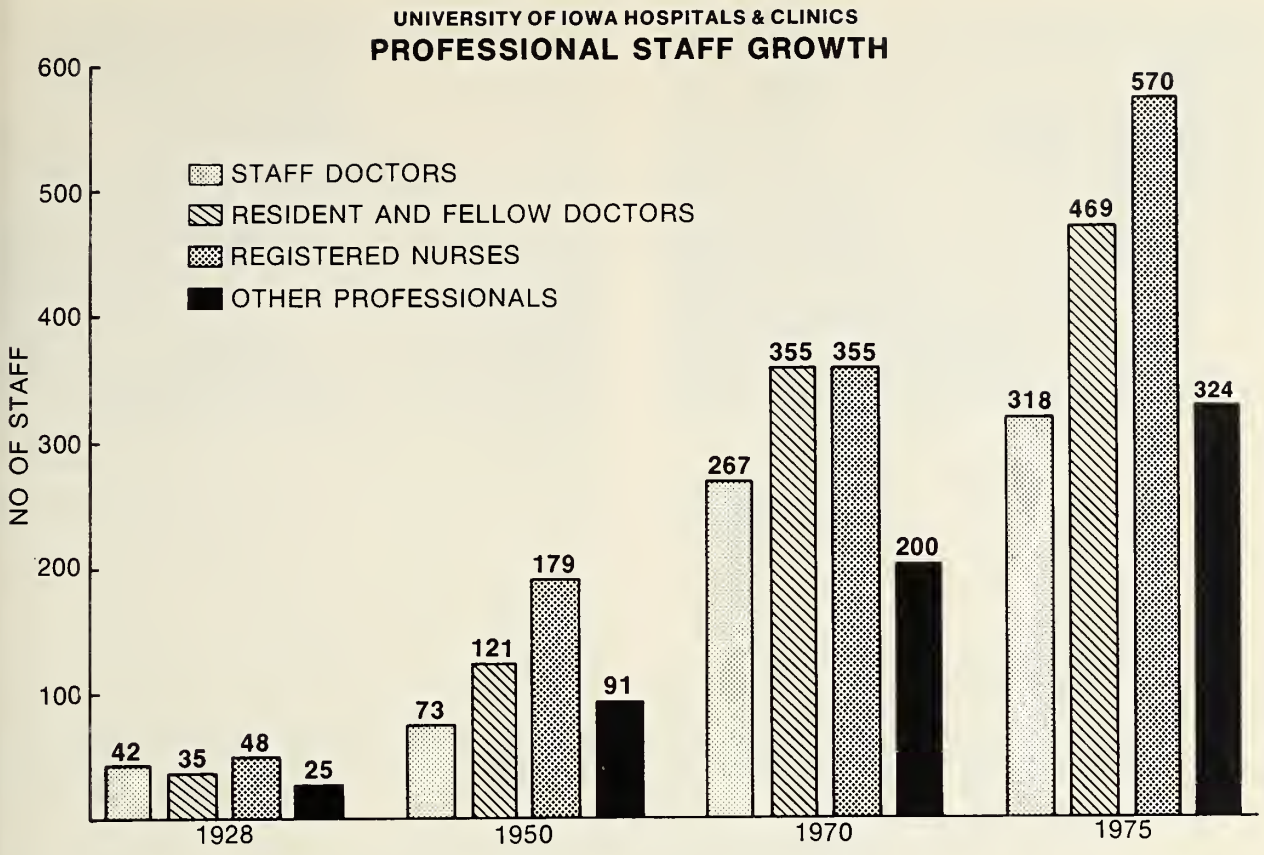
ANNUAL ADMISSIONS
1973

University of Iowa Hospitals and Clinics	32,162*
Medical College of Virginia Hospital, Virginia Commonwealth University	28,010
Ohio State University Hospitals	25,330
Duke University Hospital	25,190
Hospital of the University of Pennsylvania	24,213
Stanford University Hospital	22,522
University of Michigan Hospitals	21,764
Strong Memorial Hospital (University of Rochester)	21,710
University of Alabama Hospitals and Clinics	20,929
University of Texas Medical Branch Hospital	19,877

Source: Department of Teaching Hospitals, Association of American Medical Colleges.
* In 1974-75 the University of Iowa Hospitals had 35,901 admissions.

TERTIARY CARE

Iowa's establishment of a regional referral cen-



ter is in accord with health planning recommendations that a concentrated investment be made in facilities, technology and staff to provide efficient and highly specialized tertiary services for population groupings of between one-and-a-half and two-and-a-half-million citizens. While the total list of specialty services is long, it is worthwhile to name several for illustrative purposes. All services are delivered under the clinical direction of 787 doctors dispersed among 47 different subspecialties:

a) *Heart catheterization* facilities for both pediatric and adult patients which now serve some 900 patients per year, with approximately 40% undergoing open heart surgery.

b) A *burn center* operated by the Department of Surgery for the care of severely injured patients which serves approximately 150 patients per year.

c) A *perinatal intensive care* unit to monitor and treat critically ill newborn, many of whom are born outside of University Hospitals.

d) An end stage *kidney dialysis and transplantation service* conducted in conjunction with the Veterans Administration Hospital which annually serves 175 patients.

e) A *plastic surgery division for hand reconstruction* which serves 800 patients per year under the Department of Orthopaedics.

f) An Otolaryngology Department which accommodates most of Iowa's *cleft palate* patients, currently numbering approximately 570 per year.

g) An Ophthalmology Department which has pioneered the *ultrasound diagnosis of eye tumors* to a level where more than 1,200 such procedures are performed annually. The latest technique in lens surgery—*phakoemulsification*—and the new *vitrectomy surgery* are also performed in this department.

h) The *180-physician Department of Internal Medicine* operates a host of specialty clinics including: Endocrinology, Gastroenterology, Cardiology, Allergy, Hypertension and Renal, Pulmonary, Infectious Disease, and Hematology. The Hematology Clinic has recently installed two laminar flow units which are actually plastic rooms within rooms for care of patients requiring absolute isolation control.

i) The Urology Department has been a pioneer for three decades in the treatment of prostatic disease and now includes the *Rubin H. Flocks Prostatic Disease Center.*

j) The *Neurology Department* conducts approximately 70% to 80% of all neurological practice in the state. The broad general neurology service includes a specific tertiary orientation in the treatment of ruptured aneurisms producing stroke.

k) The Oral Surgery service accommodates 14,000 patients annually, of whom many have extensive facial trauma and gross infection stemming from systemic disease etiology.

DAILY PROFILE

The 1975 *daily* profile at University Hospitals included the following:

a) 2,000 patients
b) 787 doctors
c) 2,500 hospital supporting staff
d) 1,100 health science students

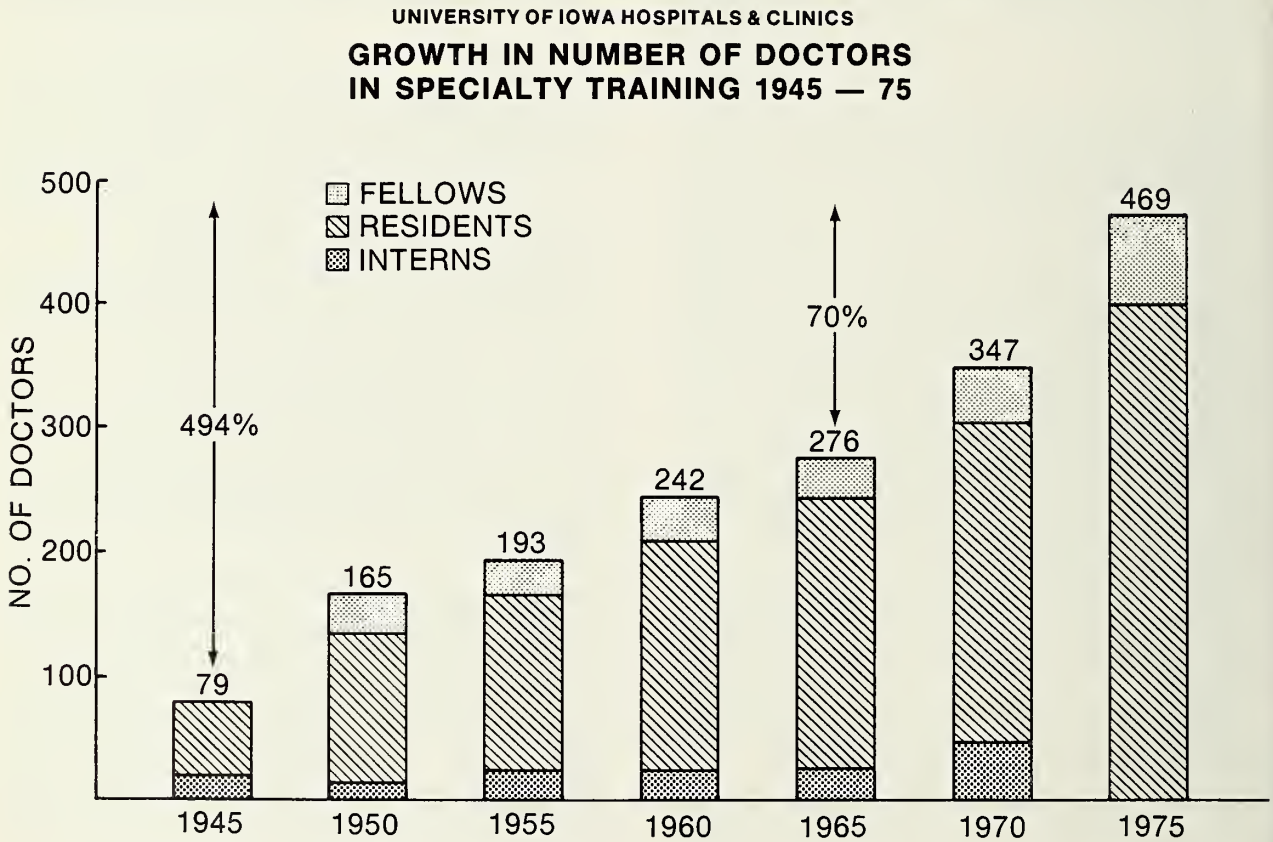
This is a daily total of approximately 7,000 concerned human beings, a figure exceeded by the population of only 37 of Iowa's 931 incorporated cities and towns, according to the 1970 official U. S. census.

OPERATING BUDGET

The July 1, 1976 operating budget of the University Hospitals (exclusive of the College of Medicine) has been given preliminary approval by the State Board of Regents at a level of $63 million. That is more than twice the budget of the municipality of Iowa City. It represents a cash flow of approximately $250,000 per weekday, most of which is plowed into the Iowa economy through expenditures for staff services, materials and supplies. With hospital capital expenditures and professional fee earnings of the College of Medicine clinical staff, totalling $20 million, the annual medical center *self-generated* earnings reach $83 million, to represent a cash flow of just under $350,000 per weekday.

CAPITAL DEVELOPMENT PLANNING

In the course of expanding the output of our enterprise over 75 years, and in attempting to



100 BEDS—Although the primary focus of University Hospitals' North Tower addition is expanded outpatient clinic facilities, 100 replacement beds are included. The inpatient nursing units were opened in February.

NEW CLINIC—Lewis January, M.D., professor of internal medicine, confers with reception staff members in one of the department's new outpatient clinics in the North Tower addition.

keep pace with the growth in health science student enrollment, the physical facilities have become saturated and to some degree obsolete. These pressures have resulted in considerable capital development upgrading in the past five years.

Phase I of this program is the *North Tower* addition, which was occupied during early 1976. This is a $15 million project with seven stories and 186,000 square feet. It consists of clinic space for ambulatory patients, new operating rooms, diagnostic radiology and 100 replacement beds. Our bed complement will remain at a total of 1,100.

Additionally, in the past 36 months a number of other capital development projects have been completed. A floor-by-floor summary of the improvements and the North Tower addition produces these highlights:

FIRST FLOOR

An additional 25,000 gross square feet and 70 examination rooms to accommodate the Department of Internal Medicine, the largest clinical department which served 43,000 patients last year.

A new Pediatric Cardiovascular Clinic addition adjacent to the general Pediatric Clinic. Its laboratory is equipped with a $250,000 cineangiographic biplane unit specially designed for diagnosing heart defects in infants and children.

In addition, 2,500 square feet have been added to the basic Radiation Therapy unit constructed in 1966. An 18-million volt linear accelerator costing $450,000 has been installed in this unit to increase our capacity in accommodating 35,000 radiation therapy treatments per year.

On the hospitals' southeast facade, the first floor of a six-story addition provides offices for Department of Surgery faculty.

Early this year, the Outpatient and Inpatient Pharmacy Services, Drug Information Center and Poison Control Center were consolidated in remodeled facilities in the center core of the first floor.

SECOND FLOOR

In the North Tower addition, new clinic and faculty office suites for the Divisions of Cardiovascular Surgery, Neurosurgery and the Department of Dermatology are now complete. An adjoining Dermatology inpatient nursing unit will become operational in May 1976.

A new Pediatric Ophthalmology Clinic and the C. S. O'Brien Ophthalmology Library have been added to the Eye Department on the second floor as well as new clinic and faculty office facilities for the Department of Otolaryngology and Maxillofacial Surgery.

THIRD FLOOR

The third floor of University Hospitals is devoted almost entirely to the Department of Internal Medicine. The goal of remodeling inpatient wards into semi-private accommodations has reduced the number of inpatient beds, therefore 32

BRAIN SCANNER—University Hospitals' $350,000 EMI brain scanner records more than 10,000 procedures annually. James Christie, M.D., professor and head of the Radiology Department, visits above with a patient following the scan procedure. University Hospitals is to receive one of the first production models of the new $580,000 EMI body scanner.

additional beds for Internal Medicine patients have been located in the new North Tower addition, bringing the total beds available for that department to just under 200.

Additional remodeling within the Hospital has created a new Medical Intensive Care Unit and an adjacent $500,000 consolidated Cardiac Inpatient Service which includes Coronary Care (6 beds), Medical Cardiology (18 beds), and Cardiovascular Surgery (21 beds) Units. In addition, Cardiovascular Laboratories have been upgraded and computerized to speed and increase the breadth of information in catheterization procedures.

Members of the Internal Medicine faculty have also been provided 7,000 gross square feet of new office facilities on this level in the 6-story southeast addition.

NORTH TOWER—Accent in the North Tower addition to University Hospitals is on convenience and personalization for the 7,000 persons accommodated in the building each day.

FOURTH FLOOR

On the fourth floor, a new $400,000 Rubin H. Flocks Prostatic Disease Center is now accommodating prostatic disease programs developed by the Urology Department.

The North Tower addition has facilitated consolidation of the Hospitals' Ob-Gyn clinic into an attractive and functional clinic facility. It is complemented by a $250,000 obstetrical nursing unit numbering 30 beds in the existing hospital, and a 32-bed, $350,000 unit to accommodate the increasing number of gynecology surgery patients.

FIFTH FLOOR

The North Tower affords a new Surgery Department inpatient nursing unit, bringing that department's bed capacity to slightly more than 200. This includes an 18-bed general surgery inpatient unit newly remodeled from Old Ward C-54 in the existing hospital.

SIXTH FLOOR

Twelve new operating rooms within the North Tower addition will expand University Hospitals' surgical capability to 25 rooms, to accommodate 15,000 major surgery procedures annually.

Readily accessible to the surgery suites are new faculty offices and teaching facilities for the Department of Anesthesia. This capital improvement includes 15 staff offices, a 58 seat "little theatre" and the Wilkins Memorial Library of Anesthesia.

SEVENTH FLOOR

The size of the Department of Radiology, which is now performing 100,000 diagnostic procedures per year, is doubled by the North Tower addition. The addition will also provide a tailor-built area for the $580,000 whole body EMI scanner which is being installed to complement the $350,000 brain EMI scanner already in use. The new whole body scanner produces a highly-detailed cross-sectioned view of any part of the body in only 20 seconds.

CARVER PAVILION

Through a combination of Federal Health Manpower, Hill-Burton, and private gift funds, the $15 million Roy J. Carver Pavilion is now under construction on the Hospitals' south facade. A $2 million gift from Mr. Roy J. Carver of Muscatine

served as the catalyst for this capital improvement.

When completed in the summer of 1977, this addition will permit the transfer of all patient care functions from the 1919 vintage Children's Hospital, which will be allocated to faculty offices and research laboratories. The Orthopaedic Department Clinic and faculty offices will also be accommodated within the Pavilion, as well as Neurology and Psychiatric Clinics and a Physical Therapy Clinic.

A prime feature of the Carver Pavilion will be a multi-specialty Trauma and Emergency Treatment Center with an adjacent heliport to receive patients who have been evacuated by air to University Hospitals.

The Pavilion addition will also contain 150 beds to replace those in Children's Hospital and to accommodate rehabilitation and TB patient care functions to be relocated from Oakdale Hospital.

At approximately the same time as the Carver Pavilion is completed, a new 693-stall parking ramp will be phased into service with connecting overhead pedestrian links to the Pavilion.

NO STATE DOLLARS

These expanded facilities have been constructed to serve the citizens of Iowa and their community physicians, and meet the University's health science educational needs, *without any state appropriated capital development funds.* Of the $40.8 million expended for the North Tower addition, Pediatric Cardiovascular Laboratory, Roy J. Carver Pavilion and other improvements over the past three years, 76% of that total has been financed by University Hospitals' operating revenues. Of the remaining cost, 17% has been met with federal grants and 7% has come from gifts to the Hospitals.

21ST CENTURY

In 1977, when the facilities which have been described are complete, University Hospitals will be prepared to render service to the citizens of Iowa and meet its educational role in adequate facilities. Then it will be necessary to move further southward in a phased replacement of other clinical facilities to provide the kind of University Hospital Iowa needs for the 21st century. The University Hospitals' staff is proud to be an element in Iowa's statewide health care delivery system and will continue to pursue its commitment to excellence.

PERSONALIZATION OF SERVICE

Lest it be thought our total efforts are related only to growth, capital development and size, it is appropriate to note our continuing emphasis with staff members on the absolute necessity to maintain constant surveillance of the "human equation" in patient care. In addition to staff personnel growth and development, a Volunteer Program, organized in 1973, has now grown to a resource of 259 very talented citizens who bring much warmth and personality to the institution. Further, a four-person Patient Service Representative Program is daily fulfilling a "trouble shooting" or ombudsman function throughout the institution for both patients and visitors.

Another important program aimed at promoting understanding among patients and staff is represented by the Hospital Information Services Department initiated in 1973. Additionally, in recent months steps have been taken to develop better and more expeditious communication with referring physicians.

COMPUTER ASSISTANCE

University Hospitals is making extensive and constant use of computer technology to increase the efficiency of its service to patients and their referring physicians. A highly refined computerized appointment system permits instant response to scheduling requests, now numbering 300,000 per year. In recent weeks, a program to provide an instant analysis of hospital bed availability and bed assignment has also been instituted.

The Department of Pathology has recently installed a $350,000 stand-alone computer to provide physicians with faster and more detailed reports on the more than two-million inpatient and outpatient laboratory reports annually.

CONTINUED EXCELLENCE

In our service role, the University Hospitals family is committed to a goal of providing the very best health care for Iowans in support of community physicians and hospitals. Over the past five years, great strides have been taken in upgrading and expanding physical and operating programs as well as devoting careful attention to serving our patients with personal, "one-to-one" care and courtesy. We are proud of our achievements, but you may be assured we shall not rest at this plateau.

Faculty Preceptorships in Primary Care

RICHARD M. CAPLAN, M.D.
Iowa City

Insights into the schedule of an Iowa primary care practitioner were gained by 23 faculty members during three-day community visits. The 18-month program summarized here indicates the unique faculty preceptorship experience was highly beneficial.

Beginning in July, 1974 the University of Iowa College of Medicine began a program called "Faculty Preceptorships in Primary Care." The program's expenses were met through December 31, 1975 by a grant from the National Fund for Medical Education, a private foundation that seeks to support innovative projects in medical education and call attention nationally to the importance of providing adequate fiscal support for medical education. Arrangements were made by the Office of Continuing Medical Education for the volunteering faculty members to spend three days in close association with a primary care practitioner. Such a look at the problems of the practitioner in his/her home setting would hopefully foster within the academic health center a climate increasingly supportive of medical students' choosing of careers in primary care. What follows will describe our objectives in more detail and the experience of the program through its first 18 months.

OBJECTIVES

To attain the general purpose just stated, several more specific objectives were identified. We wished in the case of each participating faculty member to:

a) increase his recognition of the need for primary care practitioners;

b) increase his recognition of the great challenge—intellectual, emotional, and physical—faced by primary care practitioners in our state;

c) increase his awareness of the primary care practitioner's position of responsibility, leadership and prestige in the community;

d) increase his awareness of the problems faced by the primary care practitioner in interdigitating his role and his patients' needs with secondary and tertiary care practitioners and institutions;

e) increase his sensitivity to the human caring and supportive functions of the primary care physician who works with individuals and families in a community setting—to develop an expanded sense of the art of medicine and the compassionate concern exhibited in the primary care setting, as contrasted to the compassionate concern exhibited in the tertiary care setting that is the current focus of the fulltime faculty member and has likely provided most of his professional experience.

METHOD

Each participating faculty member remained with his host physician for three consecutive working days. Ordinarily the visitor was lodged in the home of the host physician so that after-hours calls and social activities might also be experienced. The visitor was to aim for a "total immersion" into the primary care setting and its activities. A visiting physician anticipated responding to questions or seeing patients with problems that lay in the domain of his parent discipline, and in that way expected to contribute to the continuing education of the host. Some visitors also conducted a discussion session with other staff of the local group or hospital.

The community physicians serving as hosts were chosen mainly from among physicians who

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

had previously served the College of Medicine as preceptors for students.[1] Their practice settings, their expressed interest in the education of students and themselves, plus their acknowledged status as competent and dedicated physicians were already known to the College of Medicine. The practitioner was invited to return the visit by spending several days at the College of Medicine in an individualized traineeship or in some other continuing education activity of his choosing. A structured interview was conducted shortly before and after the community visit by a specially trained interviewer to ascertain in advance the faculty member's interests, attitudes toward primary care and expectations, and afterwards, his sense of accomplishment of the goals and any alterations of attitudes.

RESULTS

In the first 18 months a total of 23 faculty members completed their community visits. Eighteen were members of clinical departments (dermatology, internal medicine, obstetrics and gynecology, pediatrics, and psychiatry), three were basic science department members (pathology, pharmacology, and preventive medicine), and two others held joint appointments in clinical and basic science departments. The ages of the faculty visitors ranged from 31 to 48. Academic rank ranged from instructor to professor, and one was a department head. Only one had extensive prior experience with community practice. Ten had a brief community preceptorship experience during medical school, but no other "up-close" contact with primary care. Only one had any previous practice experience outside the tertiary care center.

In addition to the stated goal of the program, the individual faculty members had their own purposes that centered about

a. improving public relations and/or patient care by enhancing better communication between purposes that centered about

b. better fulfilling educational responsibilities toward those medical students interested in primary care careers;

c. satisfying curiosity about the purported "uniqueness" of primary care—discerning the types of problems, assessing the proportion that are of psychologic origin, estimating the time demands on the primary care physician, judging the quality of care provided by primary care practitioners;

d. learning more about referral patterns of primary care physicians;

e. assisting his department in providing more meaningful continuing education to primary care physicians.

The 23 faculty visitors from the first 18 months of experience chose practice settings as follows: 15 to family practice, 6 to pediatrics and 2 to internal medicine. The faculty members were highly impressed with the spectrum of patient care problems seen in primary care and the breadth of knowledge and skills necessary to provide such care. For example, one remarked, "I saw everything from a severely jaundiced newborn to an octogenarian who was vomiting blood." They were generally surprised at the volume of "well care" such as school and camp physicals, prenatal visits and routine screening exams.

Although it is difficult to summarize the many comments and reactions, a large majority of faculty clearly were impressed with the need for adequate high quality primary care. Many indicated basically positive feelings toward primary care initially, but agreed their experience provided reinforcement. Most came to recognize a different perspective in the relationship that does and ought to exist between primary care and tertiary centers. One faculty member returned feeling that his department should markedly alter its approach to teaching its content to medical students. One faculty member was stimulated to write some sensitive perceptions about the nature of medical practice:

"It soon became obvious to me that these guys and I had something in common: we were in the same business—*the business of being nice to people in a medical setting.*

"Any doctor who wants to enjoy his work and who wants to be any good at it, must respect his patients, must acknowledge their worth as fellow human beings with feelings and fears like his own. He must be able to identify—and identify *with*—the patient's worst fears, and from his position of knowledge and skill in the matter of illness be able to offer reassurance and, if possible, reassurance mixed with treatment. The patient must have been plenty worried or he wouldn't have bothered to go to the doctor. The doctor must be able to transfer the weight of this concern from the patient's shoulders to his own by taking on some of the responsibility for the management of the patient's illness. . . .

In short, the doctor must be nice to his patients.

"The people of this town are fortunate—they

have some excellent doctors. . . . What makes them good doctors is that they *care* for their patients, they respect them, and are willing to be a dumping ground and disposal system for their patient's anxieties on all things medical.

"They reply . . . Of course we *respect* them! How can we do otherwise? We are part of them; we go to the same church; we both postpone supper to go root for the ninth grade football team—our children are friends and classmates. If *they* are worried about something, *we listen.*

"These men are also good family doctors because they are willing to tell the patient 'I don't know'—and send the patient to a specialist. Again, this is simply a matter of honesty and respect between doctor and patient. As I said, these guys are good doctors, and watching them for three days has done something for my pride in my profession."

DISCUSSION

Although a student's choice for a primary care (or any other) career will always be a multifactorial judgment, it seems reasonable to believe a program of the type described here can be a worthwhile factor in providing the sort of friendly and informed climate that can foster rather than inhibit the choice for primary care. A longer visit than three days would improve the thoroughness of acquaintance, but would become impractical to arrange. What matters most is to allow enough personal contact to improve the "lenses" described by Michael M. Stewart, M.D.[3] in his poem "Out of Focus"—

Primary care
Is an area where
The problems, while vexing,
Appear less perplexing
When viewed from afar
(Where most specialists are).

General physicians,
Who make their decisions
Up front, though myopic,
Are close to their topic
And find their refraction
Sufficient for action.

Amidst this confusion
One step toward solution
Is finding some lenses
For far-near consensus.

ACKNOWLEDGMENT

The evaluatory design was under the direction of Dorothy J. Douglas, Ph.D., Associate Professor of Family Practice, and performed mainly by Kathy Munning, M.S., Research Assistant. Appreciation is especially given to the 23 Iowa physicians who served as hosts to the visiting faculty.

REFERENCES

1. Caplan, R.: Preceptorships in primary care: University of Iowa experience, J. Iowa Med. Soc., **65**:143-147, April, 1975.
2. Thompson, H. S.: Personal communication.
3. Stewart, M.: Out of focus. New Eng. J. Med., **292**:1061, May 15, 1975.

A Special 8-page Directory of Clinical Services at the University of Iowa begins on the adjacent page. It is suggested the Directory be removed and kept on file for reference use. ⟿

ACKNOWLEDGE SERVICE OF IOWA PHYSICIANS

During the past year eleven Iowa physicians have counseled faculty members as members of five College of Medicine committees. For this service the College wishes to thank the physicians noted below.

ADMISSIONS COMMITTEE

R. D. Whinery, M.D., Iowa City

COMMITTEE ON CANCER

R. E. Weland, M.D., Cedar Rapids

CONTINUING EDUCATION COMMITTEE

Edward W. Ebinger, M.D., Ottumwa
John Murphy, M.D., Boone
Donald J. Ottilie, M.D., Oelwein
Russell S. Gerard, M.D., Waterloo
Joellen M. Hoth, M.D., Burlington

PHYSICIAN'S ASSISTANT ADVISORY COMMITTEE

Frank B. Waites, M.D., Muscatine
Kenneth Judiesch, M.D., Iowa City

EDUCATIONAL OPPORTUNITIES PROGRAM COMMITTEE

Robert Carney, M.D., Grinnell (Consultant)
Clifford Smith, M.D., McGregor (Consultant)

Spotlighting the Class of 1979

Over 90% of the freshman class is from the State of Iowa—representing 52 counties. The 175 freshmen are 20% female with eight members of minority groups. Just over 80% were undergraduate science majors, and 11% have physician fathers.

THOMAS C. TAYLOR
Iowa City

The Class of 1979 is nearing the end of its freshman year in the College of Medicine. Its 175 members continue the trend of recent years toward stronger academic credentials, even though their selection was made from a somewhat smaller pool of final applicants (493 this year as compared to 629 last year). The decrease results from the new requirement of the College that non-residents of Iowa apply only through the Early Decision Plan.

There was a small increase in the number of Iowa applicants this year, and well over 90% of the class are residents of Iowa, coming from one or another of 52 counties. About 25% attended college outside Iowa, with 19 states represented, ranging from Massachusetts to California.

The freshmen medical students shown above are John Person, Linda Snell and Mark Hermanson. All from Mason City, they view x-rays in the Gross Anatomy laboratory.

Mr. Taylor is Coordinator of Admissions and Records at The University of Iowa College of Medicine.

Women make up 20% of the class this year as compared to 16% of the 1974 entering class, apparently reflecting women's generally increasing interest in medicine as a career. Eight members of minority groups are enrolled under the Educational Opportunities Program. As in the past, less than 30% of the class members are married.

Again this year a significant number of the first-year students—nearly one-fifth—are enrolling in medicine after completing three years of undergraduate studies. Slightly over 80% of those enrolled majored in a science-related area, with the biological sciences the most popular (41%). The social sciences are represented by six percent of the freshmen, as are such unlikely fields as agriculture, military science and meteorology.

Academically, the Class of 1979 is remarkably strong, with a mean science GPA of 3.66 and a mean over-all GPA of "only" 3.64. This compares to a mean science GPA of 3.34 and a mean over-

all GPA of 3.38 for all applicants to The University of Iowa. Medical College Admission Test scores continue to play an important role in the admission process. Here is the mean level of achievement on each subtest by the 1975 freshmen:

Test	Iowa Freshman Mean	National Percentile Rank
Verbal ability	555	58
General information	546	68
Quantitative ability	625	70
Science	625	79

In addition to their impressive academic credentials, the members of this year's class bring a record of active extracurricular lives. More than 60% of the class report participation in two or more organized extracurricular activities, clubs or committees during their last year in college. In addition, 32% held or ran for elective class or campus office while in college.

This year's new students come from a wide variety of hometowns. Sixteen percent come from the country or from towns of less than 1,000 population, and another 29% come from towns with a population numbering between 1,000 and 10,000. On the other hand, 25% of the class come from cities of 100,000 or more inhabitants.

As in the past, about 60% of the new students have fathers whose occupations are in the business and professional categories. Within this group, 25, or 14.3%, are children of fathers who are engaged in health-related careers (19, or 11%, of the fathers are physicians). Most of the new students list their mother's occupation as housewife (55%). Of those pursuing careers, most mothers are in business and professional occupations, including one who is a physician and eight in other health-related fields.

Fifty-eight percent of the mothers of the first-year students have attended college, with about half of this group having received at least a baccalaureate degree. Sixty-two percent of the fathers have attended college, with about two-thirds having received a degree. Twenty-nine percent of the fathers and six percent of the mothers have earned a graduate or professional degree.

Made up of individuals from a wide variety of backgrounds, this year's freshmen reflect the high standards of academic and personal excellence sought by the Admissions Committee and should prove to be strong additions to the College of Medicine.

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The College of Medicine Thanks Its Preceptors

The University of Iowa College of Medicine is grateful to the 132 Iowa physicians who served last year as preceptors for third- and fourth-year students, bringing them face to face with clinical problems in a variety of community settings.

Thanks are also extended to the 49 Iowa physicians and administrators who served in a preceptor capacity for the Physician's Assistant program. The names and home communities of the preceptors are listed by category.

1974-75 PRECEPTORS FOR THIRD YEAR REQUIRED PRECEPTORSHIP

SERVED STUDENTS FROM CLASS OF 1976

Ames ..... Kennedy Fawcett, M.D.
Howard Hildebrand, M.D., Paul Koellner, M.D., William McCormack, M.D.
Anamosa ..... Aaron Randolph, M.D.
Ankeny ..... James Frahm, M.D.
Atlantic ..... K. R. Swanson, M.D.
Bettendorf ..... William McCabe, M.D.
Alan Swearingen, M.D.
Bloomfield ..... Henry Perry, M.D.
Boone ..... James Hill, M.D.
Britt ..... Norman Thede, M.D.
Cedar Falls ..... Robert Bremner, M.D.
John Kaiser, M.D.
Cedar Rapids ..... Arthur Barnes, M.D.
Percy Harris, M.D., James Hood, M.D., Julius Pietrzak, M.D., Robert Swaney, M.D., John Van Tuyl, M.D., Robert Veley, M.D., James Ziska, M.D.
Cherokee ..... M. D. Hayden, M.D.
Clarion ..... Richard Young, M.D.
Clear Lake ..... James Hendricks, M.D.
Clinton ..... W. H. Griffith, M.D.
Coralville ..... P. A. McLaughlin, M.D.
Council Bluffs ..... Yuksel Inankur, M.D.
Gordon Neligh, M.D.
Corydon ..... Keith Garber, M.D.
Creston ..... Larry Goetz, M.D.
Davenport ..... John Barker, M.D.
Atlee B. Hendricks, M.D., Erling Larson, Jr., M.D., R. A. Towle, M.D., David Van Hecke, M.D.
Decorah ..... James Bullard, M.D.
David Wright, M.D.
Des Moines ..... Robert Anderson, M.D.
Stewart Olson, M.D.
DeWitt ..... Wallace Ash, M.D.
Dubuque ..... John Chapman, M.D.
Eugene Coffman, M.D., James Gilloon, M.D., David Kapp, M.D., John Moberly, M.D.
Eagle Grove ..... G. B. Hogenson, M.D.
Emmetsburg ..... Carlyle C. Moore, M.D.

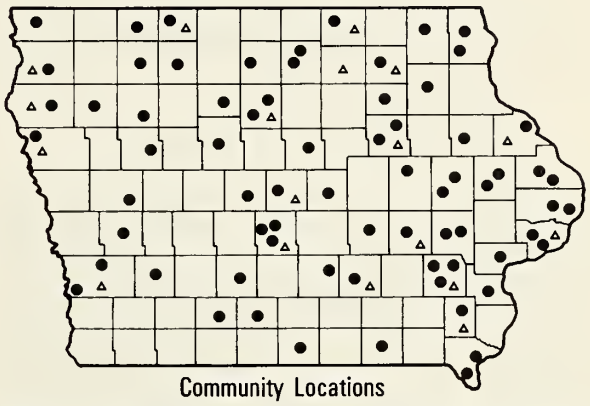


Figure 1. Third year required preceptorships involved 111 Iowa physicians in 71 communities and served 141 medical students. Dots indicate the locations. The fourth year elective preceptorship drew 23 medical students and involved 21 preceptors in 18 Iowa communities. Triangles identify these communities.

Estherville ..... J. Powers, M.D.
Fort Dodge ..... Richard Brandt, M.D.
M. E. Krauschaar, M.D., Gary LeValley, M.D.
Fort Madison ..... Harry Harper, M.D.
Grinnell ..... Robert Carney, M.D.
David Ferguson, M.D., Raymond Light, M.D.
Harlan ..... Lawrence Larsen, M.D.
Humboldt ..... James Coddington, M.D.
Indianola ..... S. F. Yugend, M.D.
Iowa City ..... Anthony Colby, M.D.
Thaddeus Bozek, M.D., Victor Edwards, M.D., Larry Rigler, M.D., Elmer Groben, M.D., K. J. Judiesch, M.D., Peter Wallace, M.D.
Iowa Falls ..... Robert Dunlay, M.D.
Kalona ..... Dwight Sattler, M.D.
Keokuk ..... Walter Kasiske, M.D.
LeMars ..... Donald Faber, M.D.
Lone Tree ..... Keith Mills, M.D.
Manchester ..... Mary Ann Arends, M.D.
John Tyrrell, M.D.
Manilla ..... John Hennessey, M.D.

Maquoketa ..... Clifford Rask, M.D.
Marengo ..... Burns Byram, M.D.
Marion ..... Paul Orcutt, M.D.
Marshalltown ..... L. O. Goodman, M.D.
Don Tyler, M.D., C. Wuest, M.D.
Mason City ..... L. W. Swanson, M.D.
George West, M.D.
Minden ..... Max Olsen, M.D.
Monticello ..... Otto Senft, M.D.
Mount Pleasant ..... Warren Scott, M.D.
New Hampton ..... James Young, M.D.
Orange City ..... Paul Vander Kooi, M.D.
Osage ..... R. Boeke, M.D.
Oskaloosa ..... Charles Argo, M.D.
Pella ..... S. F. Kanis, M.D.
Gene Van Zee, M.D.
Postville ..... M. F. Kiesau, M.D.
Preston ..... James Cahill, M.D.
Rock Rapids ..... A. C. Wubbena, M.D.
Sac City ..... David Youberg, M.D.
Sioux City ..... A. Clark Hyden, M.D.
Dale Wassmuth, M.D., Martin Zucker, M.D.
Spencer ..... John Kelly, M.D.
Spirit Lake ..... Donald Rodawig, M.D.
Storm Lake ..... Edward Laird, M.D.
Vinton ..... D. C. Weideman, M.D.
Wapello ..... Leslie Weber, M.D.
Washington ..... E. M. Ahart, M.D.
Waterloo ..... Robert E. Morrison, M.D.
Waukon ..... Louis B. Bray, M.D.
Waverly ..... James Rathe, M.D.
West Des Moines ..... Ralph Pray, M.D.
West Liberty ..... Howard Palmer, M.D.
West Union ..... Larry Boeke, M.D.
Winterset ..... Paul Chesnut, M.D.

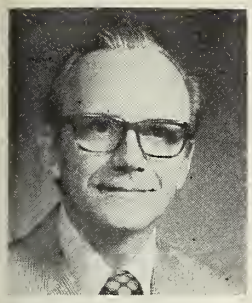
1974-75 PRECEPTORS FOR FOURTH YEAR ELECTIVE PRECEPTORSHIP

SERVED STUDENTS FROM CLASS OF 1975

Ames ..... George Hegstrom, M.D.
Ankeny ..... Rodney Carlson, M.D.
Council Bluffs ..... George Klok, M.D.
Davenport ..... Joseph Heller, M.D.
Joseph Kehoe, M.D., Edwin Motto, M.D.
Dubuque ..... Medical Associates
Eagle Grove ..... Dale Harding, M.D.
Estherville ..... D. E. Wolters, M.D.
LeMars ..... Donald Faber, M.D.
Marengo ..... Burns Byram, M.D.
Mount Pleasant ..... Warren Scott, M.D.
New Hampton ..... James Carr, M.D.
Osage ..... Richard Boeke, M.D.
Orange City ..... Roy Hassebroek, M.D.
Paul Vander Kooi, M.D.
Oskaloosa ..... D. K. Campbell, M.D.
Rockford ..... Russell Barrett, M.D.
Sioux City ..... William Jackson, M.D.
Washington ..... Gerald Nemmers, M.D.
Waterloo ..... Thomas Sprague, M.D.

1974-75 PHYSICIAN'S ASSISTANT PROGRAM PRECEPTORS

Cedar Rapids ..... William Davis, M.D.
W. J. Robb, M.D., James Ziska, M.D.
Davenport ..... Gordon Cherwitz, M.D.
Des Moines ..... David Gordon, M.D.
Veterans Administration Hospital (Des Moines): Peter Black, M.D., Rahim Bassiri, M.D., Lester Dragstedt, II, M.D., R. C. Floren, M.D., Robert Giordano, M.D., Paul Ruiz, M.D., Floyd Sarff, M.D., Jaleel Siddiqui, M.D., J. Yans, M.D.
Dubuque ..... Scott Arnold, M.D.
Eugene Conklin, M.D., Joseph Heller, M.D., Robert T. Melgaard, M.D., F. Benjamin Merritt, M.D.
Iowa City ..... John R. Maxwell, M.D.
Marshalltown ..... Daryll Eggers, M.D.
Thomas M. Foley, M.D., Axel Lund, M.D., Robert Mandsager, M.D., Philip McFadden, M.D., D. Reading, M.D.
Mason City ..... R. B. Dunker, M.D.
L. R. Fane, M.D., W. G. Garrett, M.D., J. C. Justin, M.D., Gene M. Kuehn, M.D., G. J. Sartor, M.D.
Mount Pleasant ..... Mental Health Institute: R. Aldona, M.D., John Beghtol, Director of Staff Development & Training, Albert Kaplan, M.D.
Muscatine ..... William Catalona, M.D.
Albert Kaplan, M.D., F. B. Waites, M.D.
Ottumwa ..... Stanley Levine, M.D.
Primghar ..... Everett Getty, M.D.
Andrew Smith, M.D.
Sheldon ..... Ronald Zoutendam, M.D.
Sioux City ..... J. Boyson, M.D.
Arthur Horsley, M.D., W. Jackson, M.D., Earl M. Mumford, M.D., Alan Pechacek, M.D., David G. Paulsrud, M.D.
Waterloo ..... Carl Hanson, M.D.
Luke Tan, M.D.



Editorials

M. E. ALBERTS, M.D., Scientific Editor

THE 1976 UNIVERSITY ISSUE

This traditional University Issue provides IMS member physicians a brief status report on activities and developments in Iowa City. We believe the comments of Dean Eckstein, Dr. Caplan, Mr. Colloton and Mr. Taylor do just that. Certainly apparent in their combined remarks is the broad dedication to excellence which exists at the College of Medicine and University Hospitals.

The Iowa medical profession can be proud to have an institution of this caliber available to serve the needs of the profession and its patients.

WHO OWNS YOUR MEDICAL RECORDS?

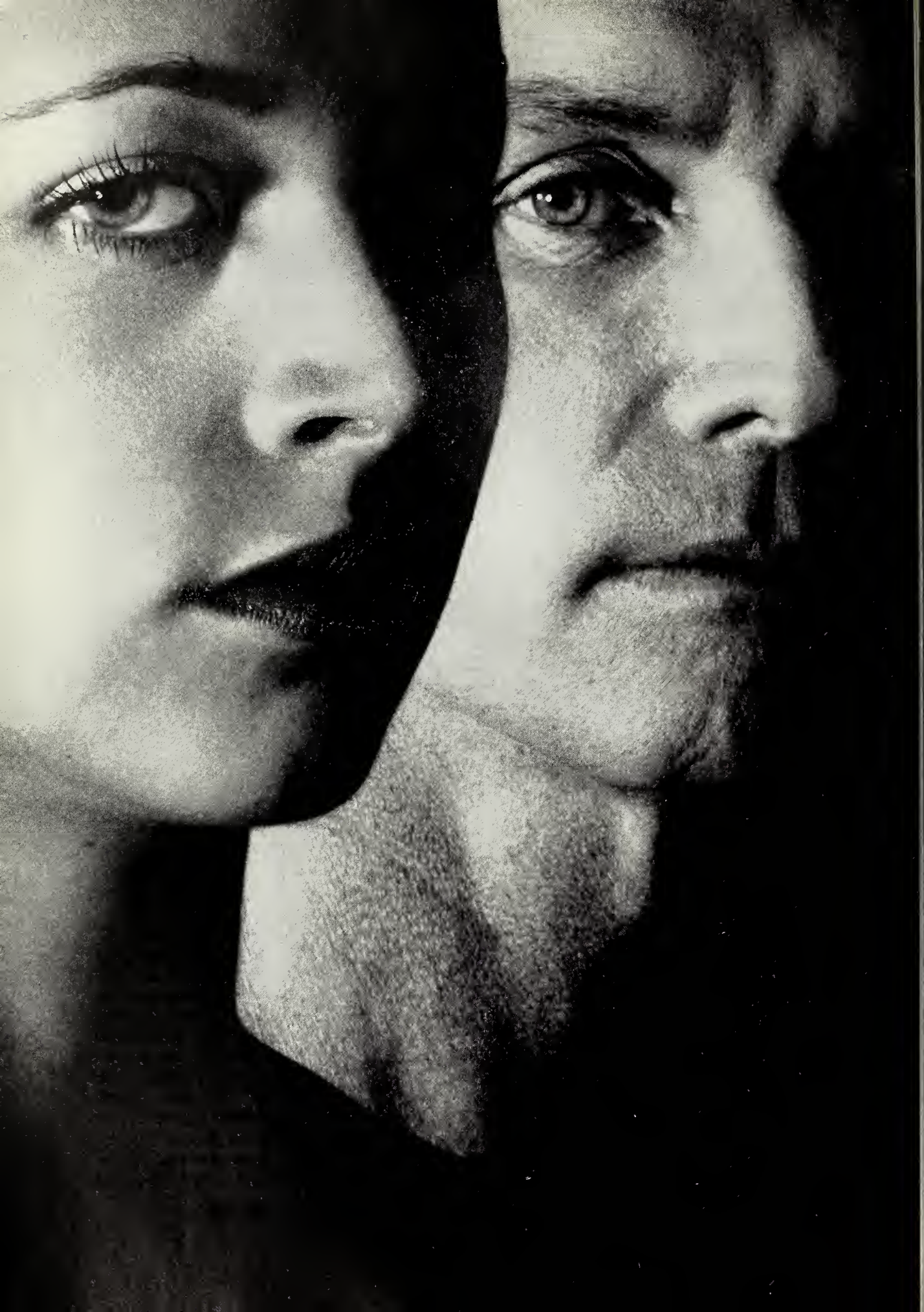
A bill (Senate File 1114) has been filed in the Iowa General Assembly which relates to the ownership of materials developed by a professional person in relationship to his client. The measure provides for a penalty, on conviction, of up to two years in the penitentiary or a fine not to exceed $5,000, or both, if a professional willfully refuses to deliver upon request, or destroys without permission, any material developed on behalf of a client. Physicians are among those included here, as are hospitals and other health care facilities.

"Material" refers to files, documents, papers, reports, X-rays, and numerous other defined items, including photographic negatives. The personal and informal work product (notes of the physician "which are not of use or value to the client") are not included in the definition of material. The client shall own all this material with the right of possession upon demand. None of the material shall be destroyed until five years after its origin, and only upon notification of such intent in writing to the client. Provision is made for delivery of the material, with responsibility for them by the professional to be absolved upon delivery and the acquisition of a signed receipt. The proposed act does not prohibit the professional from making and keeping copies of said materials.

This bill will allow a patient to accumulate and keep his own medical and legal records, X-rays, and such other materials for future reference. The explanation of the bill discounts the idea that a patient pays for opinions and services only, and not for the materials from which the opinions are derived. The author of the bill concludes such materials are of little or no use to the physician, except as they relate to the "owners who pay for them."

It would appear the author of this bill is far afield in her concept of the value of records. True, in days past paper accumulation was not a way of life; there was little to record other than observations. Now, complex accumulations are dictated by the demands for complete professional service to avoid errors of omission as well as commission. Professional persons are disciplined to retain records for future use; the client is not. For example, often I must delve deeply in my past records for information regarding injuries, immunization, or whether a person had such a simple condition as rubella in the past. People do

(Please turn to page 146)



Testing in Humans: Who, Where & When.

he weight of ethical opinion:

Few would disagree that the effectiveess and safety of any therapeutic agent r device must be determined through linical research.

But now the *practice* of clinical reearch is under appraisal by Congress, the ress and the general public. Who shall dminister it? On whom are the products be tested? Under what circumstances? nd how shall results be evaluated and tilized?

The Pharmaceutical Manufacturers ssociation represents firms that are sigificantly engaged in the discovery and evelopment of new medicines, medical evices and diagnostic products. Clinical esearch is essential to their efforts. Conequently, PMA formulated positions hich it submitted on July 11, 1975, to he Subcommittee on Health of the Sente Labor and Public Welfare Committee, s its official policy recommendations. Here are the essentials of PMA's current hinking in this vital area.

1. PMA supports the mandate and ission of the National Commission for he Protection of Human Subjects of iomedical and Behavioral Research and ffers to establish a special committee omposed of experts of appropriate isciplines familiar with the industry's esearch methodology to volunteer its ervice to the Commission.

2. PMA supports the formation of an ndependent, expert, broadly based and presentative panel to assess the current tate of drug innovation and the impact pon it of existing laws, regulations and rocedures.

3. When FDA proposes regulations, t should prepare and publish in the *Federal Register* a detailed statement assessng the impact of those regulations on rug and device innovation.

4. PMA proposes that an appropritely qualified medical organization be ncouraged to undertake a comprehenive study of the optimum roles and esponsibilities of the sponsor and physiian when company-sponsored clinical esearch is performed by independent linical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct nontherapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

EDITORIAL

(Continued from page 143)

not discipline themselves to keep such records. If a patient were given his X-rays, electrocardiogram tracings, laboratory reports, and had no discipline to safely retain those materials, they would be lost. Oh yes, the professional may make copies for his future use, to add more paper to an office already paper-engulfed.

The matter of malpractice is important in the consideration of record retention. Referral to records for this reason is always possible. Often laboratory findings are incorporated in personal and informal notes of the physician, are medical and technical, and standing alone are meaningless to the patient. One statement in the bill is very unclear: "the personal and informal work product notes of the professional which are not of use or value to the client" is not included in the definition of "material" and is so full of loopholes as to be subject to interpretation in several ways. Who is to determine what is or is not of value to the client—the client, the professional, or will this lead to more decisions by the courts? The notes made by a physician may be impressions or interpretations of his own thought-processes, yet may pertain to the patient and be of value to his welfare, but would be possibly misunderstood or totally meaningless to the patient. How does one cut, snip, censor, or otherwise separate one form of record from another. Again, who is to say which material is included within the loose boundaries of the bill?

IOWA MEDICAL MISCELLANY

(Continued from page 121)

NAMED HSA DIRECTOR . . . A Michigan health planner is executive director of Iowa's new Health Systems Agency (HSA). He's John Ross, of St. Joseph, Michigan, formerly executive director of the Southwestern Michigan Comprehensive Planning Association. Ross is a 20-year Army veteran. He assumed his duties April 1.

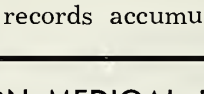
INTERNISTS MEET . . . Two-day Iowa regional meeting of the American College of Physicians will be May 7 and 8 in Iowa City. In charge of this scientific session for specialists in internal medicine and related fields is L. W. Swanson, M.D., Mason City.

Recently, I received a letter from the Attorney General questioning why I would desire to retain records of former patients who have moved from this city. He questioned why I even would "need the records." In fact, it is from him that I received the bill described here. I assume from his letter he is in favor of the bill. I have replied that until a law declares my patient records are not my property I shall retain same. Resumes of various data and copies of pertinent material will be made available to physicians who serve these patients subsequently, but my records are the property of no one else, at least at the present time.

The medical records accumulated by a physician are to be retained for his future use and reference. If a physician relinquishes his defense in a possible suit for malpractice, he stands alone. Copies may not be adequate, or actually may be questioned in a court of law as to whether they are true and correct. Is every copy made to be certified by a notary public? If the patient does not retain the original material, or even destroys it for his own devious purposes, the copies may be subject to question.

This bill is patently open to many misinterpretations, and should never be enacted into law. Study it; reflect upon its content, and voice your opinion to the members of the Assembly.—M.E.A.

MORE ON MEDICAL RECORDS



IMMUNIZATION STANCE . . . Change in IMS policy on immunization is being asked by the Committee on Maternal and Child Health. The Committee is advocating support for state legislation to make immunization a requirement for entry into licensed child care centers, elementary and secondary schools. IMS has previously backed immunization of all children on a voluntary basis.

HAWKEYE SCIENCE FAIR . . . 1976 Hawkeye Science Fair occurs April 2 and 3 at the Veterans Auditorium in Des Moines. This 18-year-old science education program for Iowa youth is sponsored jointly by the Iowa Medical Society, Scanlon Medical Foundation, Drake University and DES MOINES REGISTER AND TRIBUNE.

AMA EXCERPTS ON MEDICAL RECORDS

The following excerpts from the Opinions and Reports of the Judicial Council of the American Medical Association serve to elaborate on the editorial discussion of medical records:

RECORDS OF PATIENTS AND SUCCEEDING PHYSICIANS

At the request of the patient, preferably in writing, reports should be immediately sent to the doctor then in charge of the patient. The diagnosis of the patient's ailment is paramount in arriving at the proper treatment to be rendered, and all information which aids the physician should be furnished so that proper treatment or advice can be given without delay. Whether the contents of the report are to be given to the patient rests with the decision of the doctor who knows all the circumstances involved in the situation.

COPY OF PHYSICIAN'S RECORD TO PATIENT

The Principles (AMA Principles of Ethics) neither intend nor require that a physician give a copy of his records to his patient. These records are primarily the physician's own notes compiled during the course of diagnosis and treatment so that he may review and study the course of the illness and his treatment. The records are medical and technical, personal and often informal. Standing alone they are meaningless to the patient but of value to the physician and perhaps to a succeeding physician. The patient, however, or one responsible for him, is entitled to know the nature of the illness and the general course or regimen of therapy employed by his physician. The extent to which the physician must advise his patient may be limited by the nature of the illness and the character of the patient. The physician in advising his patient must always act as he would wish to be treated were he in a like situation.

COPY OF PATIENT'S RECORD TO ANOTHER PHYSICIAN

The interest of the patient is paramount in the practice of medicine, and everything that can reasonably and lawfully be done to serve that interest must be done by all physicians who have served or are serving the patient. When a colleague who is presently treating a patient requests records from another physician who has formerly treated the patient, that former physician should promptly make his records available to the attending physician.

No set rule can be laid down to cover the manner in which the records are to be transmitted to the attending physician. Under some conditions a personal inspection of the records might suffice; under others an oral report of what is contained in the records would be of help; or in other circumstances a summary of the records might be made. In extreme cases, a physician might lend his complete record to the attending physician. The manner of making the report—or the information contained therein—available to the succeeding physician is immaterial and will depend on the circumstances of each case. Certainly, however, the attending physician should not demand or expect more information from the former physician than is necessary to give the patient adequate care in the present illness.

It is assumed, of course, that proper authorization for the use of these records has been granted by the patient.

REFUSAL TO FORWARD RECORD TO CURRENT PHYSICIAN UNETHICAL

It is unethical for a physician, who formerly treated a patient, to refuse for any reason to make his records of that patient promptly available on request to another physician presently treating the patient.

RETENTION OF RECORDS AFTER RETIREMENT

In addition to legal requirements, there may be a good reason why a physician would wish to preserve his records for some time. In many instances the patient must rely upon his physician and his physician's records in order to establish the fact that he did receive medical care and treatment or that he has had the services of a qualified doctor of medicine. Without the physician's record the physician who rendered the care would be unable to assist his patient. Thus, in the interest of the patient, the physician should not indiscriminately dispose of his records but should give consideration to the type of practice he has and to the possible needs of his patients.

There are additional references to the handling of records in retirement, sale of records, partnership termination, etc.

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DEVOTE MORE ATTENTION TO MEDICAL LIABILITY

THE YEAR 1976 is producing further frustration among Iowa physicians over the high cost and limited availability of medical liability insurance. This exasperation is particularly acute among those medical specialists who provide high-risk services.

But of greater importance to the average Iowan is a by-product of this physician frustration—*increased health care costs*. When the professional liability insurance premium for a physician or a hospital jumps 100, 200 or even 300 per cent in a year or so, charges for health services must be adjusted upward.

In line with the inflationary spiral, which has had its extended impact on the total economy, Iowa physicians have shared in national professional liability premiums which have gone from $60 million in 1960 to $1.2 billion in 1975. When the annual liability premium of an Iowa physician jumps from $5,000 to $15,000 in a short interval, it is not difficult to understand the feeling of dismay and futility. The matter is compounded, in most instances, by the fact that the physician has had no claims filed against him.

These extraordinary increases in premiums are more than an outgrowth of our inflationary economy however. They are part of a complex societal phenomena which finds legal actions increasing 12 per cent per year nationally. Ninety per cent of all medical liability suits have been filed in the last 10 years. And these legal actions are no longer limited to alleged malpractice. They now cover many instances where the results of the treatment simply did not come up to expectations. In the end, we are seeing a boomerang effect with the high cost of liability insurance rebounding to increase the cost of health care to support a growing volume of claims, many of dubious merit.

The efforts in Iowa to alleviate the medical liability insurance dilemma have been pursued conscientiously and with statesmanship. As a result, the situation in this state is momentarily less chaotic than in other parts of the country. But the potential for a full-scale crisis exists should there be a further deterioration in the professional liability insurance market. The gains which have been made need to be maintained and more must be done to stabilize and improve the situation.

The Iowa General Assembly recognized the seriousness of the situation in 1975. It did so by passing legislation which has been at least partially responsible for the continued presence of the several insurance companies writing this coverage in Iowa. In addition, the lawmakers acknowledged the potential for a further crisis by appointing an Interim Study Committee. This eight-member committee of senators and representatives considered the problem over a six-month period. Out of the deliberations has come a report which reaffirms the complexity of the matter and notes the absence of clear solutions.

Nonetheless, in a further attempt to improve and stabilize conditions, the Commerce Committee of the Iowa House of Representatives has introduced a bill (House File 1489) which embodies recommendations of the study committee. As this is prepared, the bill has been cleared by the Commerce Committee for House action. Hope exists it will receive favorable attention.

The several provisions of H.F. 1489 include an award limit of $100,000 for non-economic loss (pain and suffering), a tightening of those quality surveillance procedures followed by the State Board of Medical Examiners, and authority to resolve medical disputes through a system of arbitration. These measures are not a cure-all, however they do build on the 1975 legislation and may help Iowa move to a more stable position. The bill has the support of the Iowa Medical Society.

In the past months, the medical profession has attempted to provide responsible leadership in finding an objective path out of the liability labyrinth. It is acknowledged that a lasting solution will take time and effort. Where alternatives appear worthy of experimentation, they will be encouraged.

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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs. In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extens burns, trophic ulceration and other extensive conditions where absorption neomycin is possible. In burns where more than 20 percent of the body surface affected, especially if the patient has impaired renal function or is receiving oth aminoglycoside antibiotics concurrently, not more than one application a day recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolong use may result in overgrowth of nonsusceptible organisms, including fun Appropriate measures should be taken if this occurs. **ADVERSE REACTION** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current lite ture indicate an increase in the prevalence of persons allergic to neomycin. O toxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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VACCINES FOR MENINGOCOCCAL DISEASE

Vaccines effective in preventing meningitis and other forms of illness due to *Neisseria meningitidis* have recently been licensed in this country. Although available, applicability of such vaccines in the civilian American population is very limited, since they do not affect the most common strains of meningococci, and they are generally not effective in children under two years of age, the age group with the highest risk of acquiring meningococcal disease. The U. S. Public Health Service Advisory Committee on Immunization Practices recommends such vaccines only for control of epidemics due to appropriate strains, and advises that they should be considered for some travelers planning to visit countries having epidemic meningococcal disease, and as an adjunct to antibiotics in the prophylactic treatment of family contacts of meningococcal disease cases.

Since their uses are so restricted, the Iowa State Department of Health does not stock these vaccines at the present time.

The official statement of the U. S. Public Health Service Advisory Committee* is reprinted below:

MENINGOCOCCAL POLYSACCHARIDE VACCINES

Polysaccharide vaccines against diseases caused by *Neisseria meningitidis* serogroups A and C meningococci are now licensed in the United States. They are prepared as monovalent and as bivalent antigens. The purpose of this statement is to summarize available information on these antigens and to offer general guidance regarding their role in the control of epidemics of meningococcal disease in the civilian population of the United States.

MENINGOCOCCAL DISEASE

Meningococcal disease is endemic in the United States and throughout the world. It caused serious epidemics approximately every 10 years from 1900 to 1945 in this country. It also regularly caused outbreaks among military recruits, which is what stimulated the development of type-specific vaccines.

During the last decade an estimated 3,000-6,000 cases a year of meningococcal disease occurred in the United States. From 1964 to 1968 and since 1972 serogroup B has been the serogroup most often isolated from patients. In 1969 through 1971 serogroup C was most common in the civilian and military populations. Serogroup A was only rarely identified. In 1971 the Armed Forces began administering group C meningococcal polysaccharide vaccine routinely to all recruits; since then, the incidence of meningococcal disease in the military has declined sharply, and serogroup C disease has been virtually eliminated.

Sulfa-sensitive serogroup B strains currently cause the majority of U. S. cases. Highest attack rates are in infants. Serogroup C strains account for about one-third of cases. Although the highest age-specific attack rate for serogroup C is also in infants, about 70% of serogroup C cases occur in persons over 2 years old. More than two-thirds of all meningococcal disease occurs in patients less than 20 years.

In recent years meningococcal disease in civilians has occurred primarily as single isolated cases or, infrequently, as small, localized clusters.

* MORBIDITY & MORTALITY WEEKLY REPORT, November 8, 1975, Center for Disease Control.

Secondary cases occur more frequently in household contacts than in the general population, and appropriate antibiotic prophylaxis has been the principal means of reducing the risk for immediate contacts of cases.

MENINGOCOCCAL POLYSACCHARIDE VACCINES

Three meningococcal polysaccharide vaccines, monovalent A, monovalent C, and bivalent A-C vaccine, are licensed for selective use in the United States. These vaccines are chemically defined antigens consisting of purified bacterial cell wall polysaccharides. The antigens are polymers of particular neuraminic acids with antigenic characteristics that induce specific serogroup immunity. Vaccine is administered parenterally as a single dose in the volume specified by the manufacturer. Adverse reactions to each vaccine are infrequent and mild, consisting principally of localized erythema lasting for 1-2 days. The duration of immunity conferred by each vaccine is unknown.

Serogroup A vaccine when evaluated in 62,000 Egyptian schoolchildren 6-15 years old appeared to be highly effective and without any serious side effects. Its protective efficacy in children younger than age 6 has not been evaluated, and antibody responses indicate that children less than 2 years old respond less well to the antigen than do older individuals.

Serogroup C vaccine has been given routinely to American military recruits since October 1971. The more than 500,000 young adults vaccinated have had no significant adverse effects. Serogroup C vaccine has been studied in infants, preschool and school-age children, and adults. It elicited antibody in all age groups, although older children and young adults had the highest levels. This vaccine does not appear to be effective in children less than 2 years of age.

VACCINE USAGE

General Recommendations

Routine vaccination of civilians with meningococcal polysaccharide vaccines is not recommended because of insufficient data on their benefits. The serogroup-specific monovalent vaccines should be used, however, to control outbreaks of meningococcal disease caused by *Neisseria meningitidis* serogroup A or C.

Vaccination may have value for some travelers planning to visit countries recognized to have epidemic meningococcal disease. Although no cases have been reported among Americans in such areas, prolonged contact with the local populace may enhance the risk of infection and make vaccination a reasonable precaution.

Vaccination should be considered an adjunct to antibiotic chemoprophylaxis for household contacts of meningococcal disease cases. This is because half the secondary family cases occur more than 5 days after the primary case, long enough to yield potential benefit from vaccination if antibiotic chemoprophylaxis were not successful.

Epidemic Control

In an epidemic of meningococcal disease due to serogroups A or C, the population at risk should be identified. It should be delineated by neighborhood, census tract, or other reasonable boundary. If there is ample vaccine, all residents in that area should be vaccinated. If not, persons expected or known to be at highest risk of disease by virtue of age, socioeconomic status, or residence area should receive priority vaccination.

At the present time, requests for releasing meningococcal vaccines for epidemic control must be approved by the Bureau of Biologics, Food and Drug Administration, in consultation with the Center for Disease Control.

Contraindications

The safety of meningococcal vaccines in pregnant women has not been established. On theoretical grounds, it is prudent not to use them unless there is a substantial risk of infection.

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EXAMINE SEX CRIMES

"Focus on Sex Crimes" is the designation for a day-and-a-half conference scheduled in Des Moines on May 6 and 7 under the direction of the Polk County Rape Care Center. The conference at the downtown Ramada Inn is for medical and nursing personnel, legal representatives, law enforcement officials, and other persons concerned in this area.

Registration and meal costs are $42. Full program information is available from the Polk County Rape Care Center, 700 East University, Des Moines, Iowa 50316.

Morbidity Report for February, 1976

sease	Feb. 1976	1976 to Date	1975 to Date	Most February Cases Reported From These Counties
denovirus	5	6	2	Floyd, Polk, Story
mebiasis	4	12	2	Boone
scariasis	2	4	1	Linn, Marshall
ucellosis	7	9	5	Scattered
hickenpox	1965	3799	2531	Bremer, Des Moines, Dubuque
onjunctivitis	329	439	270	Black Hawk, Carroll, Guthrie
ncephalitis				
type unspecified	1	2		Bremer
ythema				
infectiosum	16	32	20	Johnson, Polk, Poweshiek, Sioux
astrointestinal				
viral inf.	5382	9286	7905	Davis, Story
iardiasis	4	9		Polk
epatitis				
A (Infectious)	12	20	38	Scattered
B (Serum)	5	14	15	Scattered
unspecified	2	5	2	Polk
ookworms	1	1		Polk
npetigo	114	230	140	Scattered
fectious				
Mononucleosis	139	263	302	Johnson, Polk, Scott
nfluenza, lab				
confirmed	41	55	136	Allamakee, Johnson
nfluenza-like				
illness	11567	16295	25490	Allamakee, Buena Vista, Johnson, Linn, Marion, Polk, Story
leningococcal				
Meningitis	3	6	4	Polk, Van Buren, Winneshiek
Meningitis, bacterial	1	1		Woodbury
Mumps	218	407	226	Black Hawk, Polk
Pediculosis	72	126	81	Scattered
Pinworms	1	7	5	Polk
Pneumonia	199	278	353	Scott
Rabies in Animals	3	9	13	Adair, Clayton, Dubuque, Mitchell
Rheumatic fever	7	9	5	Black Hawk, Jackson, Jones
Ringworm, body	35	68	59	Scattered
Ringworm, scalp	2	7	3	Dubuque
Roseola infantum	1	1	2	Dubuque
Reye's Syndrome	1	1		Winneshiek
Rhinovirus	1	1		Johnson
Rubella	1	5	2	Polk
Rubeola	3	16	27	Butler, Polk
Scabies	50	142	94	Scattered
Shigellosis	4	7	16	Johnson, Polk
Streptococcal infections	3050	4875	2320	Black Hawk, Johnson
Trichuriasis	2	3		Marshall, Wapello
Tuberculosis				
total ill	11	19	10	Scattered
bact. positive	8	16	6	Scattered
Venereal Diseases				
Gonorrhea	469	1173	873	Black Hawk, Polk, Scott
Syphilis	38	73	40	Black Hawk, Polk, Scott

Laboratory Virus Diagnosis Without Specified Clinical Syndrome
Eaton's Agent 9, ECHO 9 infection 1, Herpes simplex 2, Parainfluenza *type 1 isolated* 3

FOR FAMILY PHYSICIANS

"Family Practice Network News" is a new bimonthly publication which will soon be distributed to Iowa family physicians. Its publisher is the Office of Community-Based Programs in The University of Iowa College of Medicine.

The newsletter will contain information about the University-affiliated family practice residency program in Iowa. Occasional reports regarding undergraduate, graduate and continuing family practice education will also appear along with other items of general interest to family physicians.

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PHONE _____

ABOUT IOWA PHYSICIANS

Dr. John Weresh, Atlantic, was guest speaker at recent meeting of the Southwest Iowa Diabetes Unit. Dr. Weresh spoke on "The Aging Process of Diabetes." . . . **Dr. Robert G. Gitchell,** Ames **Dr. Ronald K. Miller,** Council Bluffs, **Drs. John P. Albright** and **Bruce L. Sprague,** Iowa City, and **Drs. Darrell E. Fisher** and **Ray F. Miller,** Mason City, were named Fellows of the American Academy of Orthopaedic Surgeons at the organization's annual meeting in New Orleans, La. . . . **Dr. L. S. Wentworth,** Marble Rock physician for almost 43 years, retired March 1. Dr. Wentworth received the M.D. degree at U. of I. College of Medicine and located in Marble Rock following his internship at Ford Hospital in Detroit, Michigan. . . . New officers of the Boone County Medical Society are—**Dr. M. C. Jones,** president; **Dr. John R. Anderson,** vice president; and **Dr. John Addy,** secretary-treasurer. . . . **Dr. Robert Downie** and **Dr. Norman Westhoff** will begin family practice in Traer this summer. The two doctors are sponsored by the National Health Service Corps a federal program which attempts to alleviate physician shortages in mainly rural areas. Dr Downie received the M.D. degree at University of California in San Francisco and interned at Orange County Medical Center in Los Angeles Dr. Westhoff received the M.D. degree at U. of I College of Medicine and interned at Indiana University Medical Center in Indianapolis, Indiana.

Dr. C. J. Mikelson, Waterloo surgeon for 30 years retired January 31. Dr. Mikelson was a family physician in Osceola early in his career. . . . **Dr Kenneth D. Dolan,** Iowa City, is the new president of Johnson County Medical Society. Other officers are—**Dr. Lowell A. Luhman,** president elect; and **Dr. Thomas R. Nicknish,** secretary treasurer. . . . **Dr. L. D. Norris,** Newton, was guest speaker at recent meeting of Jasper County Nurses' Association. Dr. Norris spoke on "The New Aspects of Intravenous Chemotherapy." . . **Dr. Deepak Midha,** Creston, recently became a board certified surgeon in both the United States and Canada. Dr. Midha passed examinations of The Royal College of Physicians and Surgeons of Canada and The American Board of Surgery. He is also a member of the American Society of Abdominal Surgeons.

Medical Assistants

by TENORA MEYER, CMA

THE MELTING POT

The 1976 state convention for medical assistants will be May 14, 15 and 16, 1976, at Ramada Inn, West 2nd and Washington, Waterloo, Iowa. The program is as follows:

FRIDAY, MAY 14

4:00- 8:00 P.M. Registration
6:00- 7:30 P.M. Executive Council Meeting
8:00- 9:00 P.M. Welcome Party—Black Hawk County Chapter
9:00 P.M. Open House Campaigning

SATURDAY, MAY 15

7:00-NOON Registration
7:00- 8:30 A.M. Continental Breakfast
7:30- 8:30 A.M. Mini Test (CMA)
8:30-10:00 A.M. House of Delegates
10:15-10:45 A.M. General Assembly
Invocation
Flag Ceremony
Welcome—Margaret Gardner, President, Black Hawk County Chapter; Neil Williams, M.D., President, Black Hawk County Medical Society; Jon Crews, Mayor, Cedar Falls, Iowa; Leo Rooff, Mayor, Waterloo,
President's Message—Nancy Winter, President, AAMA, State of Iowa, Inc.
11:00-NOON Donald J. Ahrenholz, M.D.—"Reconstructive Surgery"

EXHIBIT AREA OPEN

12:30- 1:15 P.M. Luncheon
1:15- 1:45 P.M. Floral Demonstration—Bobbie Ecker
2:00- 3:00 P.M. Program—Robert Soll, M.D.
3:00- 3:30 P.M. Orientation of State Officers

EXHIBIT AREA OPEN

6:00- 7:00 P.M. Cocktail Hour
7:15 P.M. Banquet
Master of Ceremonies—Robert Bremner, M.D.
Installation of Officers
Entertainment—West High Singers

SUNDAY, MAY 16

7:30- 9:00 A.M. Continental Breakfast
7:30- 8:30 A.M. Mini Test Review
8:30- 9:30 A.M. Post Convention Board Meeting
9:45-11:00 A.M. Program
Care of the Well Diabetic—Panel Discussion—Robert Hedican, M.D., OB-GYN; Karl Jauch, M.D.; Luke Tan, M.D., Pediatrician; Richard McKay, M.D., Ophthalmologist; Dr. William Gronen, Podiatrist. Moderator: Mrs. Dixie Rohle, R.N.
11:00-NOON AAMA Representative—Jeanne Green—"Two Decades of Dedication & Service"
12:00-12:45 P.M. Luncheon
Adjournment

The Convention Chairman is Mrs. Judine Fischer with Mrs. Nina Kline as Co-Chairman. Mrs. Sandra Hayungs is Program Chairman.

DETACH AND RETURN REGISTRATION FORM WITH CHECK

Registration Non-Members	$30 (Meals and educational sessions)
Registration, Members	$25 (Meals and educational sessions)
Educational Sessions only	$ 7 (Students $3.50)
CMA Mini Test	$ 2

NAME .....

ADDRESS .....

EMPLOYER .....

ADDRESS .....

MEMBER .... GUEST .... STUDENT .... DELEGATE ....

ALTERNATE ....

Return registration and check made payable to AAMA, Black Hawk County Chapter Convention Fund to:
Mrs. Bonnie Sommer, Registration Chairman
St. Francis Professional Bldg.
St. Francis Drive (c/o Albert Dolan, M.D.)
Waterloo, Iowa 50701

Pre-registration deadline: April 15, 1976
Hotel accommodations must be made with Ramada Inn, W. 2nd and Washington, Waterloo, Iowa 50702

LIST YOUR WANTS

DOCTORS—THE NEXT MOVE IS YOURS . . . Midwest Medical, Inc. will provide you with more information about each opportunity than you have ever imagined possible. For the first time you can visually preview the Community and Medical Facilities of over 80 opportunities in the Upper Midwest, at ONE location, Saves you time, expense, and frustration. For a thorough appraisal of all factors involved, please accept our invitation to call. For discreet and confidential assistance contact M. A. Cornwall, M.D., MMI's Medical Director, or write: Midwest Medical, Inc., Lakeland, Minnesota 55043. 612/436-5161. Locum Tenens opportunities always available.

FAMILY PRACTITIONER seeks **FAMILY PRACTITIONER** to cover his practice for one year as soon as available. Salary $40,000 yearly. Week-end and vacation coverage available. Practice located in northeast Iowa. Address your inquiries to Rural Family Practice Clinic, P.C. W. H. Verduyn, M.D., 514 Main, Reinbeck, Iowa 50669.

UROLOGIST NEEDED TO JOIN one older urologist in 36-man multispecialty group. New building adjacent to largest hospital in city. Excellent recreational area. City of 65,000. Salary first year. Partnership with income based on productivity. Call collect or write: Robert A. Pfaff, M.D., 1000 Langworthy, Dubuque, Iowa 52001. 319/557-6278.

OB-GYN, UROLOGIST, ORTHOPEDIC SURGEON wanted to join established 16-man multispecialty group in Central Iowa. Immediate financial partnership. Outstanding fringe benefits. Regional hospital, excellent schools, recreational facilities. Write No. 1512, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

WANTED—ANESTHESIOLOGIST with interest in family practice, **GENERAL INTERNIST** and **FAMILY PRACTITIONER** to join 11-man professional corporation. Lucrative financial package, excellent fringes, great recreational facilities and a good place to raise a family. Hospital is seven years old, progressive and expanding. Contact M. Brentnall, CPA, Creston Medical Clinic, P. C., 526 New York Avenue, Creston, Iowa 50801.

STUDENT HEALTH SERVICE PHYSICIAN WANTED—Sports medicine interest desirable. Excellent University with attractive campus and performing arts center. Excellent fringe benefits. Salary negotiable. Contact Director, Loren L. Augustyn, M.D., Student Health Service, Iowa State University, Ames, Iowa 50010. Phone 515/294-5801.

WEST DES MOINES OFFICE SPACE FOR RENT—1,422 sq. ft. suite in IBM Building. Two private offices with carpeting and drapes. Phone Mrs. Hill at 233-1057.

INTERNISTS—Certified or Board Eligible, for five-doctor general internal medicine department in multi-specialty clinic. Subspecialty practice possible. Fine N.E. Wisconsin city of 100,000. Excellent facilities. Starting salary and fringe benefits over $46,000. Early partnership. Availability—immediate through July, 1977. Write No. 1513, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

OB-GYN—Certified or Board Eligible, to join pro-life specialist in medium sized clinic. Call presently shared by three-doctor arrangement. Fine N.E. Wisconsin city of 100,000. Excellent facilities. Starting salary and fringe benefits over $50,000. Early partnership. Availablility—immediate through July, 1977. Write No. 1514, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

PHYSICIAN ASSISTANT IS SEEKING a position with a Primary Care Physician. I wish to settle in a small Iowa town. Graduating from University of Iowa College of Medicine P.A. Program in May, 1976. For information contact David Askelson, 651 Hawkeye Drive, Iowa City, Iowa 52240. Phone 319/351-3094.

STUDENT HEALTH SERVICE—Fulltime position for qualified physician to complete staff of thirteen; excellent staff and program; accredited new facility; outstanding campus and community; salary range mid twenties; regular hours; one month vacation; Kansas license required. For further information contact: Director, Student Health Service, Watkins Memorial Hospital, University of Kansas, Lawrence, Kansas 66045. An Equal Opportunity/Affirmative Action Employer.

WELL ESTABLISHED MEDICAL AND SURGICAL GROUP desires to expand the Family Practice Department from four to six family practitioners. Salary first year—partnership second. No buy-in required. Check this one—it's an excellent opportunity in a good stable economic location with plenty of social, cultural and recreational activities. Contact either G. W. Glenn, Business Manager, or Robert A. Weyhrauch, M.D., 1125 West Fourth Street, Waterloo, Iowa 50702. Phone 319/234-1541.

PHYSICIAN'S ASSISTANT anticipates graduation from PA Program, College of Medicine, University of Iowa, this spring. Desires position in a primary care setting. Trained in current methods of physical diagnosis, data collection and limited patient management. Contact Jonathan L. Hawes, 151 Hawkeye Court, Iowa City, Iowa 52240. Phone 319/354-1375 COLLECT.

GENERALISTS and **SPECIALISTS** working together to make Hartford a better place to live and practice medicine. Thirteen physicians presently serve the area in two clinics and solo practice. There is a need for more physicians to serve this fast growing area—particularly in Family Practice and Internal Medicine. * New hospital with excellent facilities completed in 1974. * Population of 7,000. Service area population 30,000 and increasing rapidly. * Rural community flavor, close to lakes, ski areas and other recreation. * 30 minutes from major cultural, educational and social resources. This invitation to Hartford, Wisconsin is the Co-operative effort of the physicians, clinics, hospital and interested community leaders. Please contact: Hartford Physicians Search Committee, c/o N. K. Reynolds, Hartford Memorial Hospital, 1032 E. Sumner St., Hartford, Wisconsin 53027. Phone: 414/673-2300.

WEST DES MOINES CLINIC—Architect designed medical clinic on ground floor in new office building. Includes large waiting and reception area, clerical office, 5 examining rooms, X-ray room and lab, electrocardiogram room, lounge, storage rooms, doctor's private offices. Ample off street parking—up to 55 cars in a park like one acre setting. **IMMEDIATE OCCUPANCY AVAILABLE.** Please contact Roy McKay, Grodt & McKay Realty, West Des Moines, Iowa 50265. Phone 274-3511 days or 225-7919 eves.

FAMILY PRACTITIONER NEEDED—Two man group in East Central Iowa seeking an associate. New medical building on hospital grounds. Fully accredited community hospital built in last 10 years. Progressive community of 4,500 only 25 miles from complete medical facilities at Cedar Rapids and 40 miles from University Hospitals at Iowa City. Negotiated salary initially with full partnership when desired. Write or call collect to Drs. Brown & Bailey. 105 Broadway Place, Anamosa, Iowa 52205. Phone 319/462-3571 or 319/462-2255.

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DIRECTORY OF

Clinical Services

AT

THE UNIVERSITY OF IOWA HEALTH CENTER

In keeping with its long history of concern for people of all ages and stages of development, The University of Iowa offers a number of specialized services through its clinical facilities on the campus. In some instances, these are the only such services available in the state. In addition to their direct benefit to Iowans, these services are essential to the education of students in many disciplines and to the continuing education of practicing professionals throughout the state. And beyond these vital functions is the stimulation of new knowledge through research, which is an integral part of the total program.

This Directory of Clinical Services at the University follows closely the format of a booklet published in 1963 by the University's Social Work Council. It was similarly distributed to practicing professionals in Iowa for reference use. In this University Issue, the JOURNAL OF THE IOWA MEDICAL SOCIETY *and the Health Center have joined to provide updated basic information. As a further convenience, this Directory includes a section on the Veterans Administration Hospital, Iowa City, and also a listing of Community Mental Health Centers.*

Following this distribution to physician members of the Iowa Medical Society, the Directory will be made available to other professionals in the state. Physicians who would like additional copies of the Directory may write to: Health Center Information and Communication, 283 Medical Laboratories Building, Iowa City, Iowa 52242.

University of Iowa Hospitals and Clinics

University of Iowa Hospitals and Clinics is the largest of the nation's university-owned teaching hospitals. As such, it operates in support of the state's private physicians and hospitals. In addition to delivering primary health care to citizens in the immediate vicinity of Iowa City, University Hospitals is Iowa's tertiary care center. In this capacity it offers specialized diagnostic and therapeutic services.

The programs and staff of University Hospital School, Oakdale Hospital and Psychopathic Hospital are integrated administratively with the University Hospitals to afford a single hospital system. The Hospital is organized into 16 clinical services and 47 sub-specialty clinics. The clinical services include anesthesia, dentistry, dermatology, family practice, internal medicine, neurology, psychiatry, obstetrics and gynecology, ophthalmology, orthopaedics, otolaryngology, pathology, pediatrics, radiology, surgery and urology. Each of these services has its own inpatient units and outpatient clinics and, where applicable, special diagnostic and treatment units. The Hospital and its clinical programs are fully approved by state and national accrediting bodies.

To facilitate statewide use of the Hospitals' services, a patient transportation service with 15 specially-designed vehicles is available to provide round-trip service from the patient's home to the Hospital. Arrangements for this service can be made by referring physicians simultaneously with the patient's appointment.

PATIENT APPOINTMENTS

Written Requests

Written requests for all outpatient appointments should be mailed to the Director, Admissions Department. The University Hospitals *universal referral form* is requested for Private, Clinical Pay and County Pay Patients. Residents of Iowa may be referred as County Clinical Pay or State Pay (Indigent) only after county authorities have issued appropriate papers (See Financial Arrangements Section). Early receipt of the completed form will expedite the appointment process.

Telephone Requests

During regular hours (8 a.m. to 5 p.m.—Monday through Friday; 8 a.m. to noon—Saturday), telephone requests for patient admissions or outpatient appointments will be expeditiously secured by direct-dialing the appropriate clinical service appointment center listed below. Night and weekend requests for urgent patient appointments may be directed to the Emergency Admissions Unit at (319) 356-2683.

CLINICAL SERVICE APPOINTMENT CENTERS (Area Code 319)

Allergy	356-2927
Dentistry (Oral Surgery)	356-2205
Dermatology	356-2274
General Surgery	356-2902
Internal Medicine	356-2927
Neurology	356-2571
Neurosurgery	356-2237
Nuclear Radiology	356-2597
Obstetrics & Gynecology	356-2294
Ophthalmology	356-2215
Orthopaedics	356-2223
Otolaryngology & Maxillofacial Surgery	356-2201
Pediatrics	356-2229
Psychiatry	353-3932
Radiation Therapy	356-2253
Radiology (Diagnostic)	356-2575
Thoracic & Cardiovascular Surgery	356-2271
Urology	356-2421

(For numbers not listed, dial (319) 356-1616)

SPECIAL SERVICES

Emergency Service

To apprise the Hospital of the impending arrival of an emergency or trauma patient, the Emergency Service may be direct-dialed at (319) 356-2683.

Infant Ambulance Service

The University Hospital mobile nursery unit is available to transport infants residing within a 90-mile radius of Iowa City. It may be secured by dialing (319) 356-2229.

Pathology Specimens

Histopathology tissue slides on referred patients should be sent directly to the Department of Pathology with patient identification and a copy of the referring pathologist's report; also it is necessary to indicate the clinical service or physician to whom the patient has been referred and if the slides may be retained permanently. Telephone inquiries regarding the submission of histologic preparations may be directed to the Department of Pathology at (319) 356-2906.

Poison Control Center

Information regarding all toxic substances is available on a 24-hour basis at the University Hospitals Poison Control Center. The Center may be reached by dialing (319) 356-1616 and requesting the Poison Control Center.

FINANCIAL ARRANGEMENTS

University Hospitals and Clinics (and its clinical staff) is organized to provide a single standard of care to all patients, regardless of financial circumstances. The recommendation of the referring physician or dentist is helpful in determining a patient's ability to pay. Patients are assessed "full" or "partial" professional fees within one of the three financial designations described below.

Private

Most patients referred to the University Hospitals are assigned a private pay designation by the referring physician or dentist. This designation is designed for patients who can benefit from the specialized diagnostic or therapeutic care available at the University Hospitals and Clinics regardless of place of residence. Patients assigned to this category are responsible for paying professional fees in accord with arrangements made between the patient and attending staff physicians and dentists. Additionally, such patients are fully responsible for payment of hospital charges.

Clinical Pay

Patients of limited financial means (those who normally do not pay professional fees to community physicians and dentists) may be referred under the clinical pay designation. Patients so designated are responsible for payment of all hospital charges, while professional fees, beyond insurance coverage, are waived by the staff physicians and dentists involved in their care.

State Pay

Residents of Iowa may be referred under the state pay (indigent) financial designation after county authorities have issued "state papers" authorizing complete hospital and professional treatment beyond insurance coverage at state expense. Requests for treatment under this designation should be made to the County Director of Social Welfare. In some counties, the Overseer of the Poor may wish to authorize referral of such patients on a county clinical pay classification. Under this classification, charges are the same as for state pay patients, but all costs are defrayed by the county.

University Hospital School

Services

The *Developmental Disabilities Outpatient Clinic* is available for the evaluation, treatment and follow-up of physically handicapped/mentally retarded children. The Clinic's interdisciplinary evaluatory services include medical, dental, physical, occupational and speech therapies; audiology, medical social, psychology and education services. A counseling program helps parents with patient management.

A *Residential Program* of short- or long-term duration is provided for the treatment and education of the physically handicapped. Its use is determined following the evaluation process. This program is designed on an individual basis for those persons whose physically handicapping condition makes it impractical for them to attend their local school or to achieve adequate progress in the home community. Special help is available in the areas of medical, dental and nursing care; nutrition; medical social work; communication skills; various therapies; special education (including prevocational work experiences, family living, music, and arts and crafts); physical education; and recreation. Current maximum bed capacity is for 60 patients.

A *Day Program* provides special education, therapy and functional training as necessary for selected mentally retarded children and adolescents who reside in the surrounding geographic area. The special educational aspects of this program are arranged through an agreement with the local area educational agency. Up to 60 children can be accepted at any one time for the program.

Eligibility

Developmentally disabled (physically handicapped or mentally retarded) persons from birth to 21 years of age. The handicapping conditions include cerebral palsy, spina bifida, muscular dystrophy, mental retardation, postencephalopathy residuals, congenital malformations, post-traumatic residuals and other entities. Those eligible for admission to other state schools are not eligible for the Hospital School residential program. Residential care is available only to Iowa residents. After eligibility is established admission occurs as soon as bed space is available.

Referral

Arrangements for evaluation are made according to admission procedures at University Hospitals for pay classification. Following determination of pay classification, an appointment date may be established. Referrals are usually made through a patient's physician, social and/or welfare agencies, school personnel, health agencies, or directly at the request of the parents.

Further Information

Write to: Director, University Hospital School, Iowa City, Iowa 52242. Telephone: (319) 353-4131.

Child Development Clinic

Referral

The following points are suggested as a guide to referral. The Clinic is concerned with problems of mental retardation, learning and behavior which require diagnostic evaluation by a multi-disciplinary team. In addition, the Clinic offers service to children who have development or adjustment problems in conjunction with a basic medical disorder. These services are not confined to Iowa residents.

Symptoms or conditions often present in the child served by this clinic include: *Mental Retardation*—(1) failure in the preschool years to meet the developmental norms in motor behavior, speech or social interaction; or (2) inability to meet school requirements in terms of achievement and behavior. Children already known to be mentally retarded may be referred when parents or agencies in the community wish help with management or future planning. *Psychological Problems Associated with Other Medical Problems*—(1) destructive behavior and temper outbursts; (2) fearfulness and withdrawn behavior; (3) failure to conform to expectations of parents or school; (4) poor coordination and difficulty in staying with assigned tasks; (5) hyperactivity. *Learning Disabilities*—problems of inadequate performance in the classroom through lack of response to usual educational methods.

A letter describing Clinic procedures is sent to parents shortly before the date of appointment. In-

formation is gathered from the parents, school and local nursing and/or social service agencies before the appointment letter is mailed. After the evaluation, children are referred to appropriate agencies in the community. In selected cases, short-term therapy may be provided by the Clinic if no community resources are available.

Cost

The Child Development Clinic is a unit of the Department of Pediatrics at University Hospitals and charges are made according to the usual pay classifications. Referrals are generally made through or by the child's physician.

Further Information

Write to: Director, Child Development Clinic, University Hospitals, Iowa City, Iowa 52242. Telephone: (319) 353-4825.

State Services for Crippled Children

The Iowa State Services for Crippled Children (SSCC) is a statewide care system that provides specialized diagnostic, treatment and follow-up services required by handicapped Iowa children. It is an agency of the U. S. Department of Health, Education and Welfare and is administered as a public service extension of The University of Iowa.

Most young people referred to SSCC have difficult health problems that require a specialist and a special program of care. Through field clinics held twice yearly at about 50 locations across the state, SSCC provides these Iowa children with the consultative support of highly skilled persons from The University Health Center.

Services

The agency provides diagnostic evaluation in field clinics for persons under the age of 21 who have chronic diseases, physically handicapping conditions, speech and hearing problems, emotional problems, behavior disorders or learning difficulties. *General health clinics* are held for persons with chronic, congenital and multiple health problems; *cardiac clinics* assist those who have had rheumatic fever or who have heart problems; and *ear, nose and throat clinics* aid persons with these problems. *Special clinics* are concerned with muscle disorders and high risk conditions of the newborn.

Staff who travel throughout the state with the mobile clinics to conduct the examinations are Health Center specialists in pediatrics, orthopaedic surgery, otolaryngology, speech pathology, audiology, clinical and educational psychology and physical therapy. Clinic services include necessary x-ray examinations and laboratory tests.

A report of the clinic examination is mailed to the physician or other person who referred the patient. The child remains in the care of his/her own physician, and the family is encouraged to contact him/her to discuss the clinical findings and recommendations. Follow-up services are provided to assist families in obtaining the recommended care.

Eligibility and Cost

There is no eligibility requirement except for the definition of a "child" as a person under age 21. All services provided at clinics are free and are provided on a non-discriminatory basis. Any required recall visits to clinics are also free.

Referrals

Children may be referred by physicians and other persons in the community who are involved with child care. Referral forms should be mailed to Clinic Scheduling, Iowa State Services for Crippled Children, University Hospital School, Iowa City, Iowa 52242. A supply of forms may be obtained at the same address.

Further Information

For information on Clinic scheduling and patient services telephone: (319) 353-5428.

Veterans Administration Hospital

Services

General medical, surgical, neurological, acute neuropsychiatric and hemodialysis facilities.

Eligibility

Hospitalization—Any veteran released or discharged from military service under conditions other than dishonorable may be provided hospitalization if he or she states under oath that he or she is unable to defray the cost of necessary hospital care elsewhere. The "ability to pay" statement is not required for veterans who have service-connected disabilities, who are 65 years old or older, or who are in receipt of a VA pension.

Pre-hospital and Post-hospital Care—Certain outpatient medical services may be provided to prepare a veteran for hospital care and to complete treatment

of a veteran who has been furnished hospital care.

Ambulatory Care—Ambulatory care may be furnished to veterans who are eligible for VA hospital care and who do not otherwise have entitlement to outpatient care providing the following conditions exist: An application is made for hospital care and a medical determination indicates that hospital care is reasonably necessary, but might be avoided by providing ambulatory care, or hospitalization would become necessary in the immediate future if the condition remained untreated.

Referral

Veterans who report to the hospital are examined to determine their health care needs. This process will be facilitated if the veteran's hometown physician telephones or writes the Admitting Physician at the VA Hospital and gives the pertinent medical information. Veterans should bring a copy of their military discharge papers if available.

Cost

No charge to eligible veterans.

Further Information

Write to: Chief, Medical Administration Service (136), Veterans Administration Hospital, Iowa City, Iowa 52240. Telephone: (319) 338-0581.

Speech and Hearing Clinic

Services of the Clinic are of three types: (1) outclinic evaluation and consultation services for children and adults with speech, language and/or hearing problems; (2) dayclinic habilitation or rehabilitation service programs for such children and adults; and (3) a summer residential program for children with speech, language, hearing and/or reading problems.

OUTCLINIC AND DAYCLINIC PROGRAMS

Services

Outclinic evaluation and consultation services may be obtained for any type of communication problem. In addition to speech pathologists and audiologists, the staff includes a psychologist. Evaluations and consultations with physicians and persons of other health care professions within the University frequently can be arranged when appropriate. This service is designed to determine the nature of the communication problem and to provide management recommendations.

Dayclinic therapy programs usually can be arranged if the child or adult who has the problem can come to the Clinic on a regularly scheduled basis. An outclinic evaluation usually is required prior to scheduling this service and the person may be scheduled to be seen for a number of hours daily or on a less frequent basis.

Dates

These services are available from mid-September through mid-December; mid-January through mid-May; and, on a limited basis, through June and July.

Eligibility and Referrals

All children and adults are eligible for these outclinic and dayclinic services. Referrals from any source, including self-referrals, are accepted.

Costs

Fees are charged for services given. Payment may be reduced or waived for individuals unable to pay the regular fees. Upon request for a reduction or waiver of fees, a determination of what is to be paid will be made following appropriate review of the circumstances.

SUMMER RESIDENTIAL PROGRAM

Services

In conjunction with the University's Reading Clinic, a six-week residential program for some 50 to 60 children is conducted each summer. Speech and/or language work is designed to meet the needs of each child. Typically, a child is scheduled for two or three daily individual periods as well as one or more periods of group speech and language work. Children who need assistance only with reading are routinely given an hour of individual assistance daily on these skills. Group instruction in social studies, science and mathematics by listening and doing, rather than by reading, is also provided daily. For children who need help with both their oral communication and reading skills, combined programs can be arranged according to individual needs.

Children live in a University dormitory throughout this six-week period. Meals are served in a dormitory cafeteria. A staff of counselors live with the children and recreational and cultural activities are planned and supervised during non-clinic hours. A staff physician is available to manage any health problems and a psychologist assists in helping the children with any adjustment problems.

Dates

The program usually begins the second week in June and ends after the third week in July.

Eligibility and Referrals

Outclinic evaluations are usually required before April 1 for children to be considered for enrollment in the program for the subsequent summer. Referrals from any source are accepted.

For speech and/or language work, children must be between 8 and 16 years of age. Also, they must be judged (a) to be able to profit from intensive therapy, (b) to be sufficiently motivated to cooperate in the program, and (c) to be sufficiently mature to adjust to being away from home. Children with any type of speech and/or language problem are considered for admission to the program, irrespective of the cause of the problem. Children will not be accepted if their prime need for a residential program is due to maladjustment, mental retardation, or other psychological or social problems.

For the reading clinic program, students must be between 8 and 10 years of age. They must be of at least average intelligence and listening ability. Their reading skills must be so deficient as to require individual teaching. They also must be able to profit from the opportunity to participate in a classroom where no reading or writing ability is required, and they must be sufficiently mature to adjust to being away from home.

Costs

At the time of publication of this directory, total charges to families for this program were about $400. A staff member is available to work with families and statewide or local agencies if financial assistance is needed.

Further Information

Inquiries regarding services or requests for appointments should be addressed to: Director, Speech and Hearing Clinic, Wendell Johnson Speech and Hearing Center, Iowa City, Iowa 52242. Telephone: (319) 353-5463. For a child to be considered *for a reading problem only* in the Summer Residential Program, inquiries can be directed to: Director, Children's Reading Clinic, East Hall, Iowa City, Iowa 52242. Telephone: (319) 353-3175.

Children's Reading Clinic

The primary purpose of the Reading Clinic is to provide professional preparation for teachers of reading, reading supervisors and consultants, and school psychologists. In accomplishing this purpose, the Clinic gives specialized and individualized teaching to a limited number of children during the summer session in cooperation with the Wendell Johnson Speech and Hearing Clinic.

Services

(1) Administering diagnostic reading tests and suggesting remedial procedures for children referred by parents, school departments and other agencies. (2) Teaching children who are retarded in reading.

The Testing Service: Children are accepted for reading diagnosis by appointment only. Upon request an application blank will be mailed to the parents or teacher. An appointment date will be assigned upon receipt of the completed form. If the child is coming to the University for treatment or examination in some other clinic, it is usually possible to make the appointment for the same day if the Reading Clinic is notified sufficiently in advance. Only a limited amount of testing service is available. In the Clinic, diagnostic reading tests are administered to the child. The results of the tests are analyzed and a complete report is mailed to the parents and teacher.

Cost

The testing service fee is $15, payable on the day of examination.

Remedial Teaching in the Reading Clinic: Children are enrolled in the Clinic during the summer session only and are selected on the basis of tests administered in the Clinic. The general policy is to accept only children ages 8 to 10 who are average or above in intelligence but are seriously retarded in reading.

Cost

Fees and other details concerning the summer residential program may be found in the description of the Summer Speech and Hearing Clinic.

Further Information

Write to: Director, Children's Reading Clinic, Room W-317, East Hall, Iowa City, Iowa 52242. Telephone: (319) 353-3175.

College of Dentistry

Services

Dental services are provided for outpatients.

Eligibility

Any person may seek treatment for dental problems at the College of Dentistry. All treatment rendered at the clinics is provided by students and/or graduate students under faculty supervision.

Admissions

Adult clinical patients, 16 years old and older, will be screened in the Admissions Clinic. When registering, all patients will be expected to have their social security number available. Patients under age 16 will be examined in the Pedodontic Clinic.

Since these are teaching clinics, the time necessary to complete dental procedures may be somewhat longer than if the services were provided by a private

practitioner. The patient's contribution in time to the educational program is appreciated and the fee schedule for services has been adjusted downward accordingly. When a patient is accepted for treatment, every effort will be made to provide complete dental services. However, the College of Dentistry cannot assure complete treatment during any one school year. Treatment pending at the end of a term will be automatically carried forward to the next term unless the patient indicates he or she intends to discontinue treatment.

Cost

In the Admissions Clinic, all patients receive complete diagnostic services, including x-rays and appropriate laboratory tests. The fee for this service is currently $15. Fees are charged for services rendered and are due on the day treatment is provided. *No method for providing service through state assistance programs is presently available at the College of Dentistry.*

Further Information

Write to: Director of Clinics, S-316 Dental Science Building, Iowa City, Iowa 52242. Telephone: (319) 353-7101.

Iowa Mental Health Authority

Services

The Iowa Mental Health Authority (IMHA) is an agency authorized by Congress under Public Law 97-487. It was placed at the Psychopathic Hospital by the Iowa General Assembly in 1947. Financial support comes entirely from federal Public Health Service funds. The director of IMHA is named by the State Board of Regents with the advice of the Dean of The University of Iowa College of Medicine and the Iowa Committee on Mental Hygiene.

The service includes mental health education, consultation, inservice training, research and planning, recruitment and training for Iowa's Community Mental Health Centers. In 1974 the Iowa General Assembly mandated to the Authority responsibility for monitoring community mental health center standards and evaluation of programs of the centers. IMHA provides consultation to communities and agencies on organization of centers in areas of the state which are lacking community-based services.

In the fiscal year 1975, Iowa's community mental health centers served more than 30,000 patients. The centers are locally financed and controlled, making them responsive to local needs. They are private, nonprofit corporations, governed by more than 600 local board members.

Community Mental Health Centers

Referral

No legal or commitment papers are necessary. Referrals are made by physicians; medical, health and welfare agencies; schools; self; relatives; or other individuals.

Eligibility

From the area served, children and adults suffering from symptoms of emotional illness are referred to these centers for treatment.

Cost

Fees are charged according to ability to pay, as determined by the clinic staff on consultation with the patient or responsible relatives.

Further Information

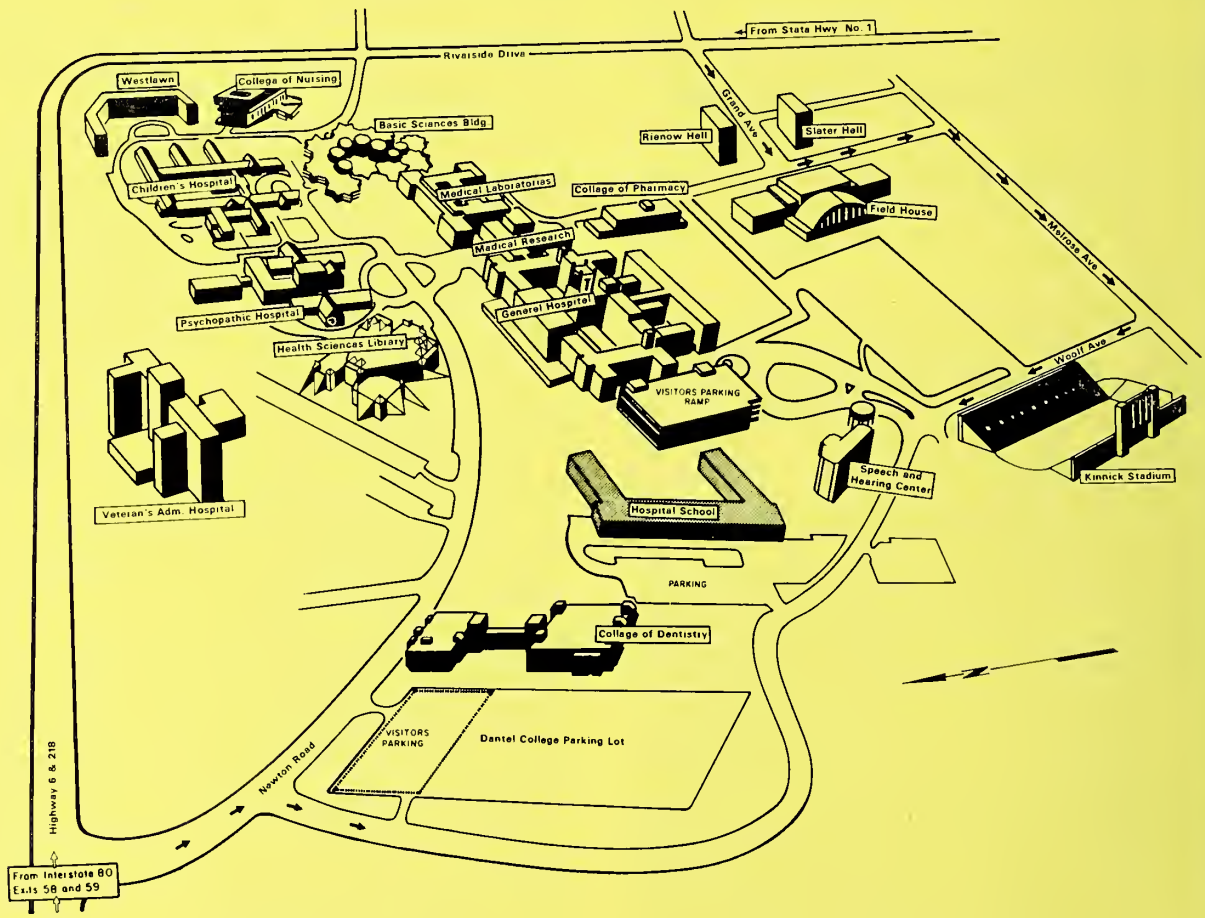
Write to: Director, Iowa Mental Health Authority, 500 Newton Road, Psychopathic Hospital, Iowa City, Iowa 52242. Telephone: (319) 353-3901.

CENTER	COUNTIES SERVED
Black Hawk County Mental Health Center 3251 West 9th St., Waterloo (319) 234-2893	Black Hawk Grundy
Cedar Valley Mental Health Center P.O. Box 114, 112 Second St., N.W., Waverly (319) 352-2064	Bremer, Chickasaw Fayette, Butler
Central Iowa Mental Health Center 223½ Main St., Ames (515) 232-5811	Story, Boone, Greene
Community Mental Health Center of Henry, Louisa, Jefferson Counties, 505 S. White St., Mt. Pleasant (319) 385-8051	Henry, Louisa Jefferson Washington
Community Mental Health Center of Scott County 1441 West Central Park Ave., Davenport (319) 326-6491	Scott
Crossroads Mental Health Center 206 N. Elm St., Creston (515) 782-5283	Union, Clarke
Des Moines Child Guidance Center 1206 Pleasant St., Des Moines (515) 244-2256	Polk, Warren
Comprehensive Mental Health Center of Eastern Iowa Mercy Medical Center, Dubuque (319) 588-8513	Dubuque, Jackson
Great River Mental Health Center 1608 Cedar, Muscatine (319) 263-1801	Muscatine
Jasper County Mental Health Center 2009 First Ave. E., Newton (515) 792-4012	Jasper
Lee County Mental Health Center 1013 Concert St., Keokuk (319) 524-3873	Lee
Linn County Psychiatric Clinic 400 3rd Ave., S.E., Cedar Rapids (319) 398-3562	Linn
Mental Health Center of Clinton County 226 Tucker Building, Clinton (319) 243-5633	Clinton
Mental Health Center of Mid-Iowa One North 4th Ave., Marshalltown (515) 752-1586	Marshall, Tama, Hardin

CENTER	COUNTIES SERVED
Mental Health Center of North Iowa P.O. Box 1463, Mason City (515) 424-2075	Kossuth, Winnebago Worth, Mitchell, Hancock Cerro Gordo, Floyd, Wright, Franklin
Mid-Eastern Iowa Community Mental Health Center 302 S. Gilbert, Iowa City (319) 338-7884	Iowa Johnson, Cedar
North Central Iowa Mental Health Center Trinity Regional Hospital, Fort Dodge (515) 576-7144	Pocahontas Humboldt, Calhoun Webster
Northeast Iowa Mental Health Center 305 Montgomery St., Decorah (319) 382-3649	Winneshiek Howard, Allamakee Clayton
Northwest Iowa Mental Health Center 1120 First Ave., E., Spencer (712) 262-2922	Lyon, Dickinson Osceola, Emmet, Clay O'Brien, Palo Alto, Buena Vista
Orchard Place, Children's Residential Treatment Center 925 S.W. Porter Ave., Des Moines (515) 285-6781	All Iowa
Plains Area Mental Health Center Floyd Valley Hospital, Le Mars (712) 546-4624	Plymouth
Polk County Mental Health Center 1301 Center St., Des Moines (515) 243-5181	Polk, Warren

CENTER	COUNTIES SERVED
Pottawattamie Mental Health Center 719 S. Main St., Council Bluffs (712) 328-2609	Pottawattamie Harrison
Poweshiek Mental Health Center General Hospital West, Grinnell (515) 236-6137	Poweshiek
Rathbun Area Mental Health Center 708 S. Main, Centerville (515) 856-6471	Lucas, Wayne Appanoose
Siouxland Mental Health Center 611 Jennings St., Sioux City (712) 252-3871	Woodbury
South Central Mental Health Center Mahaska County Hospital, Oskaloosa (515) 673-7406	Marion, Mahaska Keokuk, Monroe
Southeastern Iowa Mental Health Center 521 N. Fifth St., Burlington (319) 754-5749	Des Moines
Southern Iowa Mental Health Center 1001 E. Pennsylvania, Ottumwa (515) 682-7511	Wapello, Davis
Southwest Iowa Mental Health Center 1408 E. 10th St., Atlantic (712) 243-2606	Carroll, Shelby Audubon, Cass
West Central Iowa Mental Health Center 2111 Green St., Adel (515) 993-4514	Guthrie, Dallas Adair, Madison
West Iowa Mental Health Services Memorial Hospital, Denison (712) 263-3172	Ida, Crawford

THE UNIVERSITY OF IOWA HEALTH CENTER



respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium®
(diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

President's Page

When you read this page I will be your immediate past-president.

I would like to express my thanks and appreciation to the membership of the Iowa Medical Society for granting me the opportunity and privilege of being your president this past year.

We would have accomplished little without the help and work of the other officers of the Society, the district councilors, the AMA delegates and alternate delegates, and the many Society committee chairmen and members.

I give special appreciation and thanks to all the executive staff—there are no words that adequately compliment them for the help they have given to me and the Society.

On behalf of the IMS officers and members, I wish to pay tribute to the IMS Auxiliary. This is the group that gives us far more help and support than most anyone realizes.

I humbly pass the gavel to our new president, Dr. Jim Bishop. I hope and believe we have made some progress this past year. I know Dr. Bishop has the ability, the leadership and the foresight to guide the Society in a constructive manner this coming year.

I extend my best wishes to Dr. Bishop and all members of the Iowa Medical Society.

Sincerely,

V. L. Schlaser MD

V. L. Schlaser, President

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The Question Box

by DONALD L. SWEEM, M.D.

ANESTHESIOLOGY LIABILITY!

Donald L. Sweem, M.D., Des Moines, has followed Iowa medical liability developments closely on behalf of the Iowa Society of Anesthesiologists. He comments here on the situation from the perspective of this specialty group.

Anesthesiology has been hardest hit in the medical liability dilemma. What is your specialty's current situation in Iowa?

The anesthesiology situation is again most grave with respect to the umbrella or excess coverage. Many of our members face renewal in mid-summer, thus the full gravity of the situation will soon become evident. The availability of basic coverage has been no problem, but premiums between $3,000 and $18,000 per man were paid last year by our members for their total liability coverage. A few members who are either (1) in multi-specialty groups covered by admitted companies, or (2) on the tail-end of a three-year commitment will have no severe problems again this year.

Are there any reported instances now where coverage is just not available on any kind of acceptable basis?

Yes. Four of our members have quit the practice of anesthesia. Several of our members in a total of five cities have been forced to practice with the basic policy only.

Have conditions improved, stabilized or deteriorated in the past three or four months?

Conditions in anesthesiology have deteriorated in the umbrella market since October of 1975. Hartford has recently announced a withdrawal from Iowa and three of our members are trying to replace this coverage. St. Paul has indicated it will write anesthesiology for claims-made basic coverage only, and Aetna has said it is reluctant to write anesthesiologists switching from inadequate or non-renewed insurance programs. Medical Protective is writing only basic limits in Iowa. These comments acknowledge the improvement in the availability of basic coverage. Any Iowa anesthesiologist may obtain a basic policy.

What brief general comments do you have concerning the medical liability problem as it relates to Iowa?

The claims experience for anesthesia in Iowa has been excellent and certainly does not reflect the exorbitant insurance premiums we are paying. Like other states we are struggling to resolve the medical liability problem by passing laws to update or change the outmoded tort system. This updating is necessary due to changes in our modern society. Many of our mechanisms for recovery are the products of an earlier, more primitive society when an eye-for-an-eye philosophy was more prevalent. The Iowa legislature offered some rays of hope with the passage of House File 803 last year. However, further legislation limiting liability, as passed in Indiana, Nebraska and Idaho will be necessary to resolve the problem. Physicians cannot continue to practice medicine and provide a welfare program for those with results of less than 100%. This burden placed on us by society is becoming too great.

It may be too late to save the practice of anesthesiology in Iowa, even if the current legislative proposal is passed. The facts are (1) an anesthesiologist can no longer practice part-time anesthesia; (2) young physicians are hesitant to enter anesthesia residencies; (3) anesthesia groups are reluctant to expand, and (4) the states with more attractive liability insurance programs are attracting the younger anesthesiologists.

The Philosophy of Raising a Family

DENNIS H. KELLY, SR., M.D.
Des Moines

These thoughts about the needs of young people will benefit today's physician—as a parent and as a practitioner. They were written several years ago by one of Des Moines' most respected physicians. They are printed here as a tribute to their compassionate author whose kindness will be long remembered.

IT HAS BEEN MY PRIVILEGE to practice medicine for over 25 years, to enjoy the experience of observing a generation of infants develop into young adults. I would like to express to you something of the philosophy of raising a family, and more particularly the physician's role in shaping the family pattern. What I have to say is uttered with humility, both as parent and doctor.

With the passage of the years, it has become more and more obvious that the basic need of children is a wholesome, harmonious pattern of family life. What our children turn out to be is simply a reflection of the spirit of home, of interpersonal relationships which provide utter security, unquestioned affection, implicit trust, mutual respect and understanding, and the opportunity for each to maintain individuality.

The physician should and can contribute generously to the wholesomeness of the family life of his patients, and in so doing he renders a service which will assure the development of happier and better integrated adults. This phase of medicine is time consuming and one is never remunerated commensurate with the time and effort expended, but it is just as gratifying as contributing to recovery from illness.

The office visit consists of a physical evaluation of the child, the assessment of growth and development, the consideration of habits, the protection by immunization, the elaboration of the emotional pattern of the respective age level. This is the opportunity to bring out inter-personal relationships within the home—I like to look upon it as a time of family inventory, a taking stock of home situations, an objective perspective of goals and values. I am confident this is helpful if the expressions of appreciation of grateful parents are any criterion.

The inventory is not accomplished by simple interrogation, but requires a certain subtlety of analysis. It should not be a sermon but rather an unburdening and an evaluation, guided by skillful leading. If one employs the analogy of marriage to explain parent-child relationships, it is surprising the number of marital difficulties that come to light. Most problem children are created by problem parents, and if one can contribute to the solution of basic marital conflicts, one adds materially to the fundamental security of the child.

Parentage not only implies biologic maturity, emotional maturity is essential. I choose to define maturity as that stage of development in which the individual finds gratification and happiness in giving rather than getting. It is unfortunate that so many ostensibly mature adults find their pleasure only from what they receive for themselves per se, and such people contribute little to family life. To illustrate, I have a baby under my care who was rejected by his mother, and the first months of his life at home were chaotic. The mother was raised in an affluent and indulgent home, she attended one of the finest colleges in the East, majoring in science. To her, marriage is a far over-rated institution. She is hypercritical of her husband, she resents the work and attention entailed by motherhood. She has found no emotional satisfaction and is wrapped up in her own unhappy sacrifice. Her son will present many behavior, habit and personality problems in the

Dr. Kelly was scientific editor of the JOURNAL OF THE IOWA MEDICAL SOCIETY from 1961 to 1971. He was in the private practice of pediatrics in Des Moines from 1928 to 1955. He died March 29, 1976. So far as is known, this manuscript has not been published previously.

succeeding years, deprived of the love and security to which he is entitled.

The first opportunity the physician has to contribute to a stable and wholesome parent-child relationship is before the baby is taken home from the hospital. The parental needs are not so much detailed instruction concerning the feeding and physical care of the baby, but rather to project a sound and sensible philosophy of management compatible with the emotional needs of the infant and the welfare of the entire family. For the good of all concerned, one must imbue a mother with confidence in her ability to cope with her new responsibility and to disregard the multitude of advice in which no two ideas ever seem to coincide. The baby is entitled to be treated as a human being and not a plaything. There should be no imposition of rigid, arbitrary schedules or patterns; however, there must be a reasonable order or the babe will soon be a tyrant. The new mother must be admonished not to lavish all her affection and attention on her infant—all husbands still want to be fussed over and spoiled, and older children's place in the family pattern must not be jeopardized. In the office visits during the first year, the physician gets a clear picture of the situation of the baby within the home and the reaction of the parents to their new charge. He can help create wholesome relationships.

SECOND YEAR CHALLENGE

The first year is usually a happy time for both baby and parent. It is in the second year, when the passive, lovable infant becomes an assertive, aggressive, investigating human dynamo, that the troubles begin and the fur begins to fly. At about one year of age, the parents should be prepared for the succeeding months by understanding the common mistakes and the basic needs of their child.

Through the years, I have had an opportunity to observe mistakes which are prevalent in most households. Parents are prone to expect perfection of children, but not of themselves, and make no effort to understand the behavior and drives and needs of the respective age levels. There is a constant tendency to impose more grown-up behavior, habit and attitude when it is obvious that a child will act his own age, regardless.

The cardinal sin is the incessant conflict over behavior that is normal, the eternal "No, No," the bossing, the raised voice, the slapped hands, the spanking, the inconsistency of the adult in his relationship with the child. Why is it that adults can accept with tolerance the peculiarities, the idiosyncrasies, the thoughtlessness, the frailties of other adults, but be so lacking in understanding and so intolerant of their child? Too often there is a lack of unanimity on the part of the parents. They must present a united front.

The basic needs of children are few but they are so fundamental and so necessary if we are to help them become wholesome happy adults. I am certain the first requisite is a happy home with parents who are emotionally mature and happily married. It does not take very long to evaluate the husband-wife relationship, and if they need help a qualified counselor should be sought.

SECURITY NECESSARY

Security of affection is as necessary to the child as food and warmth, but this does not mean maudlin sentimentality. We all see the two extremes—rejection on the one hand, over-possessiveness on the other—both equally bad and both engendering habits and personality trends which leave permanent scars. There may result the cowed, submissive, withdrawn and unhappy youngster or the aggressive, belligerent, asocial bully.

In addition to the security of affection, the child needs a feeling of implicit trust in his mother and father, with never a faltering of his confidence. This can be accomplished in only one way—by the child's own consistent experience day after day, week after week, month after month in the intimacy of home. It is a conditioned response, just as the animals in Pavlov's experiments. The secret is an understanding of the age and a knowledge of normal behavior at the respective age levels, and the willingness to accept normal behavior as normal, and not prompted by malice or the devil. In other words, it is just playing fair with the youngster.

If we want our children to trust us we must make few commands, but once made they *must* be carried out. In the average household, the child is constantly told what to do, what not to do, to stop this and stop that, and it is just as ineffectual as the golf swing that is not followed through. Trust and respect are created only by consistency and fairness. Every youngster is entitled to just as much courtesy and consideration as any adult in the home, and mother has to be fully as patient with the children as she is with their father—and what husband is there who would not try the patience of a saint? Sometimes even wives are puzzling!

I do not wish to imply that children should not mind. They must mind, but we must be reason-

able in what we expect. If they are to acquire respect for us and for our judgment and decisions, we must be fair, firm and consistent. Whether Johnnie is 3 or 14, we hope to have his cooperation because he has learned to trust us and to have faith in us and not to comply because of fear of consequences. Spanking is prompted by anger and usually jeopardizes the very thing we are trying to create between parent and child. If disciplinary measures are in order, isolation is effective and does not engender fear.

ACCEPTANCE IMPORTANT

Just as husbands and wives must accept one another as they are, so parents must accept their children as they are—tall or short, fat or lean, blond or brunette, calm or high strung, brilliant or dull. Our task and our responsibility is to surround our offspring with an environment conducive to their normal growth and development—physical, mental, emotional and moral. There is a common tendency to squeeze children into preconceived patterns, to make of them something different from the individuals whom they are, which of course just cannot be done and results only in emotional tension and conflict. The individuality of the child must be respected and it is the parental responsibility to help him utilize his endowments to the very best of his ability. Initiative, self-reliance and resourcefulness can be developed at an early age. What children turn out to be depends not so much on what they do or do not do throughout childhood or what we make them do, but rather what we do as parents.

Companionship is essential to this boy or girl, doing things with them and showing an interest in their activities and drives. The average father is so engrossed in his profession or business he has no time for childish things. Too many mothers are so wrapped up in the mechanics of running a household they lose sight of the fundamental goal of family life. The hours devoted to the play and the interests of our children, and the warmth of companionship will be mutually rewarding.

Those attributes which constitute character are acquired at the mother's knee. Wholesome concepts of honesty and integrity, ideals, standards of conduct, kindliness and tolerance, are not inoculated into the child by the tip of the tongue or the index finger, but are acquired over a period of years and determined by parental example.

Just last week the father of a sixth grade boy called asking for an immediate appointment because of a serious and critical problem with their

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

son. The mother and father entered the office breathless and on the brink of a calamity. Their boy was lying—"lies roll off his tongue like honey."

After the parents calmed down, I found Jack had told two lies. The first one was pure confabulation. There had been a contest at school to select the best speaker to initiate a school project and the boy came home reporting he was the winner of the contest. Mother and dad were thrilled over his success, helped him with his speech and had him practice it over and over. At a PTA meeting a few days later, talking to Jack's teacher, it was found that his story was untrue. This precipitated a crisis at home and shame was heaped upon child and parents. Tickets to a Drake football game were torn and thrown in the waste basket for "liars cannot associate with decent people." Jack was deprived of any social activities and there would be no movies until January 1. Three days later, Jack told a second lie—a simple fib to escape blame for an inconsequential offense.

PROBLEM HANDLING

My first question to the parents was, "Did you ever tell a lie?" Both emphatically denied ever telling a falsehood. "Did they ever make a mistake?" "Rarely."

Of course, the pertinent issue was not Jack's two lies, but rather why did he lie?

The parents are both teachers in their mid-forties, colorless, austere and humorless. They love their only son, but they are veritable martinets.

Jack is an awkward, poorly coordinated boy with jug ears. He has had a difficult time at home and his social adjustment with his peers has not been easy, but he has acquired a nice group of friends. He has been poor in sports and in choosing up sides for a game he has been the last one chosen. His intelligence is superior. He plans to be an astronomer. I asked him to explain gravity and his explanation was very clear. He knew the planets and their relative position to the earth. The boy escapes the realities of life by frequent fantasies—he is Huck Finn or Robin Hood.

Jack's first confabulation was prompted by a desire to bolster his ego and to win the approval of his parents. The second lie was uttered to spare himself further reprisals.

The boy needs more affection and more understanding. He needs praise and encouragement. He must be permitted to be all boy and not made to conform to a rigid, arbitrary pattern. Home must be a happy place and not a court room.

The basic values possessed by our young people reflect the values manifest within the home. As parents, our fervent hope and prayer is that our children become adults who are not only healthy but happy. Wholesome values are essential to real happiness—finding pleasure in simple things which are within the realm of the attainable. Love of nature, good books, music, art, scientific or intellectual curiosity, participation in sports provide a sounder basis for happiness than social position or material possessions. Somehow we must help our children acquire the basic philosophy that it is not what one has that is important but rather what one *is* and what one *gives* that makes life rich.

There must be inculcated a certain element of practicability. Industry, thrift, purpose in life, vocation must not be imposed but encouraged and directed. Every child should have work to do and contributions to make within the home. An allowance gives experience in the use of money and the budgeting of funds to meet their needs. Interest in mechanics, the arts or the sciences should be encouraged and frequently solves the problem of vocation. The choice is the child's.

The basic pattern of parent-child relationship is determined in the pre-school years. If a solid, wholesome foundation is created, the succeeding years are smooth sailing. In general, children of grade school age are busy and happy if not constantly inhibited and directed. Busy youngsters are not problem children. Constructive enterprise necessitates some effort and imagination on the part of the parent. The funny magazine, the radio or television can and frequently do occupy all of their time out of school—these are poor substitutes for baseball or football or scouting or building a shack in the back yard. They do have their place in the entertainment and education of the child but not to the exclusion of team play and the give and take of association with others.

ADOLESCENCE

The average parent finds adolescence a difficult period and many teen-agers certainly find life complex and difficult. I am amazed at the number of high school boys and girls who are bitter and rebellious toward their parents. If wholesome, happy relationships have been created in the early years, adolescence is not difficult. However, it does require understanding and patience and a willingness to relinquish the boy or girl from parental apron strings. Above all else, the adolescent resents being treated as a child—the

imposition of rigid hours; being told what to do and what not to do; incessant criticism of table manners; eternal conflict over what they wear, how they don't take care of their clothes or their room; the battle over mowing the lawn or washing the dishes; the heckling over failure to be on the honor roll; the question of how many dates; conflicts ad infinitum and ad nauseam. No wonder the child is bitter and rebellious.

TYPICAL STORY

Quite a typical story is that of a girl I have cared for since infancy, now a high school senior. After her physical examination, she was questioned about school, home, social activities, hobbies, interests and ambitions. Out of this it was clear that she was well adjusted, doing well in school, and happy everywhere but at home. Conferring with the mother in the absence of her daughter, it was obvious the conflict at home was between father and daughter. He dictated her life, what she wore, where she went, who she dated, when she went to bed. On several occasions in the last year he had slapped her sufficiently hard to produce a black eye. Of course she was rebellious and justifiably so. There was nothing wrong with the girl, but the father treated her as a child instead of accepting her as a lovely 17-year-old. I had the temerity to call the father to the office and pointed out he was alienating his daughter, rather than fostering the lovely relationship which should obtain. He acknowledged his mistakes and the atmosphere changed completely.

Let the parent imbue his boy or girl with the idea that he trusts them implicitly and they will live up to that trust. They should avoid being bossy and dictatorial and arbitrary and nagging. Parents must preserve and foster the adolescent's feeling of absolute security, of implicit trust and confidence in mother and father, rather than jeopardize the relationship over inconsequential things. Of course, there must be a reasonable order in the home, there must be firmness or the child is just as insecure as he who is possessed and dominated.

The child who grows up in the home in which religion is an integral part of everyday life will find it an increasing force and influence, be he Protestant, Catholic or Jew. In this day of materialism, spiritual and moral values are at a premium. Integrity and honesty are no longer the keystones of character, but rather adroitness, chicanery and subterfuge are the accepted order of the day. Whatever one can get by with is acceptable. There can be no equivocation about honesty and integrity—there is no place for compromise. The Sermon on the Mount continues to be an infallible guide of human conduct, Supreme faith an everlasting source of strength and comfort.

After children are married, they should be permitted to lead their own lives and to raise their children according to their own philosophy. Parents must relinquish their children to sons-in-law and daughters-in-law, and in no way interfere. They cannot expect the devotion and attention which was natural and normal when their children were young. Jealousy, hurt feelings, animosities, jeopardy of the marriage, great unhappiness are fostered by parents who still dominate their married children. Loyalty and support should characterize their action and word, rather than criticism and domination. Grandchildren are not the responsibility of grandparents and it is not their prerogative to dictate as to how they are managed or raised.

Likewise, young married couples must accept one another's parents as they are and not adopt a chip-on-the-shoulder attitude toward mothers- and fathers-in-law. Kindness and tolerance and understanding should foster a lovely relationship between the two generations.

We take great pride in those children who have grown up under our care, who have attained maturity—healthy, happy, wholesome and useful. For them we have a real affection and a possessive feeling. We hope we have, in some small measure, contributed to their achievement.

OUR FAILURES

Where have we failed the child and the family of the juvenile delinquent, the high school girl who becomes pregnant, the boy or girl who is unable to face the realities of life with poise and courage?

If we take pride and a measure of credit for the successes, we must acknowledge our culpability for these tragedies. Somewhere we have failed the child, and it is reasonable to assume that the parents, who relied upon us for guidance, feel that we must share their blame and their shame.

The physician's task is not just the physical care of the child. He must help nurture the whole child. A cursory physical examination, a shot in the arm and a diet list put in the mother's hand is not pediatrics. The energy and effort devoted to creating a wholesome pattern of family life, to participate in the solution of basic problems within the home will help to make this a better and happier world.

SCIENTIFIC ARTICLES

Colorado Tick Fever In the Rocky Mountain States

BRUCE BECKORD, M.D.
Estes Park, Colorado

This summary of Colorado Tick Fever is meant to alert Iowa physicians to an endemic disease of the Rocky Mountain states which may not manifest itself until the patient has returned to the Midwest.

COLORADO TICK FEVER (CTF) is an acute viral disease transmitted by the bite of the wood tick *Dermacentor andersoni*. Increasing interest in backpacking and hiking in the Rocky Mountain region by Midwesterners should encourage Iowa physicians to become familiar with this disease. They should consider CTF in the differential diagnosis of any patient with an unexplained fever who may have recently been in the West.

Dr. Beckord is a native of Rolfe, Iowa. He was graduated from Grinnell College and the University of Iowa College of Medicine.

Colorado tick fever is not the only tick transmitted disease in the Rocky Mountains, but it is certainly the most common (Table 1).[1]

It is frequently confused with Rocky Mountain spotted fever (American tick-borne typhus) which is primarily a disease of the East (Table 2).[1]

TABLE 1

AVERAGE ANNUAL INCIDENCE, 1969 TO 1973, OF TICK TRANSMITTED DISEASE IN THE ROCKY MOUNTAIN STATES*

	Tularemia	*Relapsing Fever*	*American Tick-borne Typhus*	*Colorado Tick Fever*	*Tick Paralysis*
Colorado	0.6	0	2.4	120.6	1.2
Montana	1.4	0	1.8	9.2	0
Nevada	0.2	0	0.6	0.4	0
New Mexico	0.6	0	0.8	0	0
Utah	15.4	0.2	0.8	11.8	0
Wyoming	1.6	0	0.4	0.6	

* Incidence is reported as cases per 100,000 population. Tick paralysis is not routinely reported in these states, and relapsing fever is routinely reported only in Utah.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF MAY, 1976.

TABLE 2

STATES WITH HIGHEST INCIDENCE OF TICK TRANSMITTED DISEASES

Tularemia	*Relapsing Fever*	*American Tick-borne Typhus*	*Colorado Tick Fever*	*Tick Paralysis*
Texas	Arizona	Ohio	Colorado	Colorado
Oklahoma	Texas	Maryland	Utah	Northwestern U.S.A.
Arkansas	Washington	Virginia	Montana	Western Canada
Virginia		N. Carolina	Canada	
Illinois		S. Carolina		
Tennessee		Georgia		
Missouri		Tennessee		
		Alabama		

CLINICAL FEATURES

The most common clinical features of CTF are fever (101°-103° F), headache, and severe myalgia. The onset of symptoms is abrupt (many patients can recall the actual hour of onset) and usually follows the bite of the tick by 3-4 days. A biphasic temperature pattern frequently occurs in which a two-to-three day febrile period is followed by a remission for a few days and then another two-to-three day febrile period. Lethargy for several days following the acute episode is not uncommon. A macular or petechial rash limited to the trunk has occasionally been reported.

EPIDEMIOLOGY

The area of distribution of the wood tick *Dermacentor andersoni* includes much of the northwest part of the United States. The virus is essentially limited to the distributional area of the tick which is the only known vector responsible for transmission of the disease to man. Colorado tick fever may be present from March until August, but the peak incidence is in May and June. All age groups may be affected, but the incidence is higher in young adult males who are more actively engaged in activities that bring them into contact with the ticks. *D. andersoni* is more readily contacted in brushy areas between 4,000 to 9,000 feet elevation and is more active following a rainfall.

LABORATORY

A leukopenia of 2,000 to 3,000 cells/cu mm, involving both granulocytes and lymphocytes, is a consistent feature of the disease and is most readily observed during the second febrile episode. Isolation of the virus and fluorescent antibody staining has proven highly reliable. The virus is stable for several days in whole blood at room temperature so shipment can be made without refrigeration. Viremia may persist for more than a month so the time of taking blood specimens is not critical. Antibody formation is sometimes slow and of little diagnostic advantage. A blood clot and serum specimen may be sent to: Vector-borne Disease Division, Department of Health, Education, and Welfare, Post Office Box 2087, Fort Collins, Colorado 80521.

TREATMENT

Conservative management of CTF consists of bedrest, analgesics, and fluids. Antibiotics are of no therapeutic value except for secondary infections. Complications are infrequent, but include bleeding diatheses, meningitis, meningoencephalitis, and encephalitis.

SUMMARY

Colorado tick fever, the most common febrile illness transmitted by a tick in the West, should not be confused with Rocky Mountain spotted fever. The diagnosis is based upon a history of a recent tick bite, biphasic temperature curve, leukopenia, and isolation of the virus with fluorescent antibody staining. Complications are infrequent. Treatment consists of supportive therapy without antibiotics.

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Irreversible Coma and Cerebral Death

JOHN T. BAKODY, M.D.
Des Moines

More emotional than thoughtful. This is how the author characterizes much of the thinking regarding the determination of death. He calls for increased understanding of irreversible and reversible coma and brain stem function.

The Karen Ann Quinlan case has struck a nerve in the contemporary scene. It has been reported extensively and discussed by physicians, attorneys, clergymen, sociologists, euthanasia advocates and, of course, editorial writers.

Is there a constitutional right to die? Why can't people be spared costly and protracted care in a critical medical situation? Why doesn't the doctor withdraw life support when the family wants him to do so? There are various opinions offered and the solutions suggested are myriad and many times more emotional than thoughtful. Does the problem yield to rational analysis?

To improve understanding, we need to define and analyze some of the essential elements. There is a need to define coma; to understand the brain stem functions and to contrast reversible and irreversible coma. Euthanasia should be defined and attention needs to be given to the ordinary and extraordinary maintenance and resuscitative efforts in the care of a critical patient. Brain death will need to be defined.

There is the patient's level of response to his surroundings. The state of wakefulness requires an arousal response of the organism, based in large part upon function of the brain stem reticular activating substance. Loss of this arousal response results in coma which is either reversible or irreversible.

Whether coma in a particular patient will become reversible or remain irreversible is frequently impossible to predict. Since there are no dependable predictive indices, there is a hesitancy to label a persisting coma as irreversible in less than 100 days (and there are reported cases which have reversed after more than this) as long as there is any evidence of brain stem function, even though fragmented. (From newspaper accounts and without personal knowledge of the patient, it does appear the unfortunate Quinlan is in irreversible coma.)

VITAL FUNCTIONS

It is important to distinguish between irreversible coma and brain death. To further understand this, the vital functions of the brain should be considered briefly. The vital functions essential to life are represented in the brain stem. These include:

1. Pupillary constriction to light represented in the rostral midbrain.

2. Extra-ocular movements in response to changing position of the head. This is frequently referred to as the Doll's eye test and is dependent upon vestibular impulses reaching the intact nuclei of the eye muscles. These events are represented in the midbrain, pons and medulla oblongata.

3. Closure of the eye to touching the eye-lid or cornea. This requires an intact reflex arc from the trigeminal afferents to the facial nerve efferents. This has been called the ponto-bulbar reflex.

4. Eye movement response to caloric stimulation of the tympanic membrane which requires transmission of impulses from the labyrinthine vestibule to the eye muscle nuclei.

5. Gag-reflex, requiring the passage of afferent fibers from the pharynx and excititation of the muscles involved in gagging.

6. Spontaneous respirations, due to activity of the respiratory center in the medulla.

(Please turn to page 178)

Dr. Bakody is in the private practice of neurosurgery in Des Moines, Iowa. He is a member of the Iowa Medical Society Committee on Organ Transplantation.

Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

7. Response to the environment, due in large part to the reticular activating substance.

Non-function or absence of all the foregoing items is consistent with brain death, with the exception of patients in a profoundly hypometabolic state due either to toxicity from agents such as barbiturates, to hypothermia or to a combination of these events.

IRREVERSIBLE COMA

In irreversible coma, in addition to the loss of the arousal response, other vital functions may be paralyzed, but not all of them. There is still brain stem function, but after a period of several months the individual still does not respond to the environment in any appropriate fashion. In reversible coma, after initial paralysis of arousal, the patient does finally respond to the environment after a lapse of days, weeks or several months. In both of these situations, there is, of course, clinical evidence of brain stem function, even though respiratory assistance may be required.

After the physician decides that brain death has occurred, the heart may continue to contract since heart action is not dependent upon brain stem function. In such instances there seldom arises problems where the physician and family mutually agree to removal of mechanical life supports. There does arise a real problem, however, when the brain stem continues to function in a fragmented fashion, with persisting coma and the family now requests withdrawal of life supports. Here, we do not have a cerebral death but a viable brain stem and quickly we are talking about euthanasia.

EUTHANASIA

Euthanasia means the action of inducing a merciful, easy or painless death—*the action of inducing death.*

Not too many years ago in Iowa, a jury could find an individual guilty of first degree murder and the judge would sentence him to be hanged by the neck until he was dead. The prisoner would then be taken to Fort Madison and a professional hangman would carry out the details. If society wants to take action in inducing death, then society should provide the public executioner—the authorized withdrawer of life support.

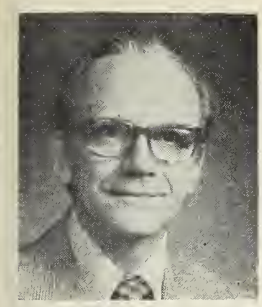
The second Vatican Council tried to distinguish between ordinary and extraordinary methods of sustaining life in the seriously ill, injured and dying. It is a good concept but fails often in specific application. For example, the physician starts mechanical respiratory assistance on a comatose patient who shows brain stem function and the potential, at least, for coma reversibility. But brain stem paralysis ensues and at some point the physician identifies cerebral death. Has not the respirator, which before its application to the patient might have been considered extraordinary, now become an ordinary assist? And what of the patient with incomplete brain stem function, requiring mechanical respiratory assistance, and with hope for reversal of coma, but whose coma persists for many months, well beyond three or four months? Has not the respirator by this time become part of the ordinary care of the patient?

CEREBRAL DEATH

The physician can diagnose cerebral death, when all the clinical and other findings confirm non-perfusion resulting in brain stem paralysis and finally massive cerebral infarction, if you will. In this situation, the doctor, in conjunction with the next of kin, can make the decision as to whether mechanical aids should be continued. In effect, the physician here can become the one to withdraw life support, in person or by agency. On the other hand, the cessation of support for irreversible coma, requires a decision by society, not the physician. Now we are talking about euthanasia, the action of inducing death, however merciful it is thought to be, in an individual whose brain stem still is viable although incompletely so. Let society, not the physician make the judgment here, pass the sentence and then be prepared to bring in its public executioner.

NO HEROIC MEASURES

An alternate situation arises during patient care, where the patient is usually mature or elderly, and the next of kin does not wish to initiate extraordinary means of support. Eschewed are intratracheal tubes, mechanical respiratory assistance, etc. If the physician does not wish to acquiesce in this situation, he can always bow out and turn over patient care to another.



Editorials

M. E. ALBERTS, M.D., Scientific Editor

MEN TO REMEMBER

Two close friends of the JOURNAL have died during the past month. We often speak of the departed as being "gone," but pleasant thoughts shall remain forever in our memory when we recall these two gentlemen. On these pages is written a tribute to Dennis H. Kelly, Sr., past scientific editor, by his friend, and colleague, Lee Forrest Hill. Dr. Kelly continued his interest in the JOURNAL following my succession to his post. His guidance and encouragement were very helpful to all of us.

Herman Smith, an associate editor for a number of years, likewise provided a most valuable service to the JOURNAL as well as to the Society. His years as Speaker of the IMS House of Delegates, and subsequently, as a Delegate from the IMS to the AMA, were fulfilling to him as well as the Society.—M.E.A.

DENNIS H. KELLY, SR., M.D., 1897-1976

All of us who have been friends and colleagues of Dr. Kelly were saddened by his recent death. He joined the pediatric family in Des Moines in 1928 after a pediatric residency at the Children's Hospital in Boston. He quickly developed a large and satisfying practice and was beloved by his patients and their parents, as well as by his fellow physicians and the house and nursing staffs at all hospitals.

His first misfortune—healthwise—came in 1943 during World War II when he was executive officer at Fort Fitzsimons in Denver, Colorado. Here he developed a moderately severe coronary thrombosis which incapacitated him to some degree for the rest of his life, although he recovered from the initial attack sufficiently to resume his pediatric practice. Some years later he suffered a second incapacitating illness in the form of pulmonary sarcoidosis. In time the acute phase of this disease subsided, but it left him with considerable scarring of both lungs and pulmonary insufficiency of moderate degree. A third illness, although not of life threatening proportions, but most unpleasant for a number of years, was psoriasis which at times covered most of his body and required the application of soothing ointments, often several times during the night, by his devoted wife, Aileen.

In spite of such serious afflictions as these, Dr. Kelly maintained an active pediatric practice for as long as he was physically able. Eventually he was forced to retire. But even in retirement he continued his interest in medical affairs by serving 10 years as scientific editor of the JOURNAL OF THE IOWA MEDICAL SOCIETY.

He is survived by his wife, Aileen, and four children—Kathleen, Michael, Dennis and Brian—all of them having achieved notable success in their own fields. We extend our heartfelt sympathy to them in their loss of a devoted father and husband.—LEE FORREST HILL, M.D.

IOWA MEDICAL MISCELLANY

(Continued from page 165)

HSA PROGRESS . . . $533,676 has been approved by HEW for the Iowa Health Systems Agency. This amount is considerably less than the $1.5 million budget contained in the grant application. New Executive Director John Ross cited two personal goals in April 12 meeting of HSA Board: (1) to build a better health care system, and (2) to contain costs of such a system to make it affordable. Paul Pietzsch, of the Health Planning Council of Central Iowa, has been named HSA associate director.

MEDICAL LIABILITY . . . Representatives of Medical Protective, Aetna and St. Paul met April 15 with the IMS Medico-Legal Committee to assess the availability of malpractice insurance. Major crunch continues to exist in the excess or umbrella area. Anesthesiologists present at the meeting confirmed problems associated with excess coverage.

ELECTED . . . James A. Clifton, M.D., professor and head of the Department of Internal Medicine at the U. of I. College of Medicine, was chosen president-elect on April 8 of the 33,000-member American College of Physicians. He is the only Iowan to assume this post.

EMERGENCY MEDICAL SERVICE . . . EMS plan for Iowa has been completed and is to be circulated to all hospitals in the state. Plan contains a regionalized concept following geographical divisions similar to the HSA subarea designations. Prospects are the EMS program will become a facet of the Health Systems Agency.

IOWA MEDICAID . . . Prospects are between $50 and $55 million will be available in state funds during the next fiscal year for the Iowa Medicaid Program. This is expected to be several million short of the need based on current utilization. Vendor groups have met in April with Department of Social Services to submit recommendations for cost or service curtailment. IMS has noted potential of PSRO to monitor Medicaid-funded care.

★

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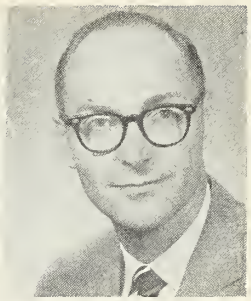
Educationally Speaking



by RICHARD M. CAPLAN, M.D.

WHEN IS A CARROT A STICK?

Much of the conversation and publication of the past several years tend to make continuing medical education a stick. That is, you either engage in educational activity or you will suffer an unpleasant consequence. For example, one might lose hospital privileges, lose membership in a medical society, forfeit one's status as a certified specialist in family practice, or even lose one's license to practice medicine. On the other hand, certain new procedures that one might learn have a yield in cash, that is, they are marketable at a personal profit for the operator or clinic (e.g., coronary angiography, hip replacement, etc.). There are some other benefits, however, that should be emphasized more than usually happens —the personal satisfaction of learning and using new information and skills, and the giving of ever better service to one's patients.

A new approach to award-psychology (holding out a carrot) has appeared in a recent restructuring of the pay scale of fulltime physicians in VA hospitals. Such staff are now granted $500 extra in their annual salary if they hold a current AMA Physician's Recognition Award. You may correctly surmise that I have had a flurry of telephone calls asking questions about the AMA award, how one counts hours, which categories are which, and so on. It should not surprise you that rewards induce efforts and achieve results. Dog trainers in the circus, psychologists training mice or pigeons, or effective teachers and leaders all know this and operate in this way, whether or not they ever had a course in Pavlovian conditioning, modern marketing, or encounter-group therapy.

To give a tangible reward prized in our society ($$) for continuing education isn't new. Most of our public school systems have long given monetary awards for extra increments of formal study by their teachers. The professional teacher's certificate in Iowa must be renewed every 10 years by taking 6 semester hours of college work related to one's teaching area. It's a little like keeping a batch of sourdough starter "fresh" or replenished by adding a little new flour or sugar from time to time. Taking such courses is to protect from the adverse consequence of losing one's certificate (i.e., job and livelihood). The positive consequence is that increases in educational quanta, usually measured in 15 semester-hour steps, are rewarded by pay raises.

It takes a greater maturity, a "higher" sense of professionalism to continue one's life-long learning for the less tangible rewards. All of us are complex beings, though, and our responses will be motivated by a mixture of highers and lowers, or carrots and sticks. To some extent at least, each of us has a choice about whether we will seek carrots, or just wait to be hit by the stick.

INTERNATIONAL PARLEY

The first International Conference on cholesteatoma will be in Iowa City May 26-29 under sponsorship of the U. of I. Department of Otolaryngology. The meeting will be at the Highlander Inn.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

give her a present

Being a successful professional person means that you are also a very busy person. Chances are you haven't enough time to manage your finances with thoroughness and careful attention to detail. Further, the chances are, unless you already have a financial manager, your wife is handling the chore. Now, really, is it fair to expect her to perform a function that takes years of training and experience to learn? Give her a vacation from your financial problems. She's earned it. Bring your investments and financial problems to your Iowa bank. We have the skill and training to make it pay off for you, and an Investment Management Account or Living Trust will spare you both a lot of bothersome details. It'll be like giving your wife her very own accountant, investment counsellor and a vacation all tied up in one package. And our fee is deductible. You win no matter how you look at it. See us soon. Iowa Trust Departments can save you time and money. And can save your wife, too.

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State Department of Health

DEAF SERVICES PROGRAM

The 1975 Iowa General Assembly created a Deaf Services Program within the Community Health Division of the Iowa State Department of Health. Iowa is the sixth state to develop such an activity. This article will describe the special problems of deafness and the role of the new program. Iowa physicians are invited to share the problems they encounter in providing services to our deaf citizens.

The handicap of deafness is difficult to imagine. A deaf person does not necessarily look or behave differently. How can those of us who have always known a hearing world grasp the impact deafness has on deafened individuals? It is not easy. Harder still is the deaf person's realization that it is the hearing world's lack of understanding that often makes his handicap more burdensome.

Personalties and abilities vary in the deaf population as in any other groupings of individuals. There are, however, some important distinctions to be made. The type and degree of hearing impairment must be determined. It additionally is vital to know the age of the onset of deafness. There are three broad age categories: (1) Prelingual; (2) Pre-vocational; and (3) Adulthood.

In the (1) Pre-lingual category are congenitally deaf individuals or those who have serious complications or illnesses in early childhood resulting in deafness before age five. Such persons are often excluded from the formative language process. Since language is a basic ability unique to the human species, the absence of its development during the fundamental formative years will have a critical impact on a person's life. Still many motivated deaf children are able to progress. The majority are not limited by their minds or other intrinsic abilities, but are limited by their opportunities to be informed and by other extrinsic learning experiences.

Pre-vocational deafness (2) occurs when a person loses hearing before the age of 19 years. This can include the prelingually deafened group; however, a hearing loss after age five years can add hardships to the learning of (a) family sharings and responsibilities, (b) community functions, and (c) job training skills. It is understandable that jobs which require technical or complex communication skills may not be suited to the young deaf person—even if the teenager desires the training. Yet, most jobs can be modified with little or no extra effort or expense to accommodate the deaf. However, they are not changing, but are remaining strictly geared to the general, non-handicapped population. This may not be intended, but the applications and licensing procedures often test the applicants' language skills rather than their vocational talents and skills. Most deaf employees are excluded from the equal opportunities of job placement, security and promotion. Those deaf persons with bright minds, creative talents, exceptional skills and high motivation are mostly relegated to unskilled, semi-skilled or routine factor labor. This under-employment occurs despite the successful records demonstrated by the small percentage of deaf persons employed in professional, administrative and related business-type positions.

The third age category is (3) Adulthood (age 20 or older). In this instance, personal and familial adjustment can be traumatic. New manipulative skills may be required to accomplish a job change that is not desired. The retired person who becomes deaf often finds the isolation from conversation, information and sounds difficult to cope with and accept. Deaf adults are most likely able to express in understandable and grammatically correct spoken English. However, the total loss or

garbledness of receptive sounds and words can be devastating.

Estimated census calculations of the deaf population indicate there are 185,017 hearing impaired persons in Iowa (ranging from hard of hearing to total deafness), of which approximately 27,000 are deaf (including all ages of onset from birth to old age), and of this number 6,778 persons became deaf before the age of 19 years. The following figures indicate both the United States and Iowa population estimates of hearing impaired persons. None of these figures include imprisoned or institutionalized deaf persons, nor those deaf persons with severe multiple handicaps.

	U. S.	*Iowa*
Hearing impaired	13.4 Million	184,017
Deafened at any age	6.5 Million	27,052
Pre-lingually and prevocationally deafened	1.7 Million	6,778

A few years ago a group of Iowa deaf adults and their advocates began to make the needs of the deaf known to those in the state government. As a consequence, the Deaf Service Program was created. The initial appropriation supports a director at this time. As needs are prioritized and plans are made, appropriations for staff and program implementation are expected. The basic function of the Deaf Service Program will be to coordinate or facilitate state-wide services for all deaf persons of any age or ability. The program is more specifically concerned with (1) assuring that health, social, personal, education, and related services are available to the deaf in a usable manner; (2) establishing and maintaining relationships with public and private agencies, organizations, and professional people on behalf of the deaf, and (3) planning and implementing specialized programs to aid deaf persons where no such service exists—an example being interpreting services. A seven member, Governor-appointed advisory committee provides program guidance. All professionals, agencies, other advocates and volunteers are encouraged to provide comments and input. The collection and dissemination of varied information on the needs of both the deaf consumer and the public-service provider will be on-going. It is hoped such interdisciplinary and collaborative efforts by various groups and individuals will result in improved services for deaf citizens.

The medical profession has a crucial role in (1) early infant screening, (2) early childhood disease treatment, (3) correct diagnosis, and (4) proper referral. The earlier the identification of deafness, the sooner these children can be given language models (not just speech) with which to build conceptual inner symbols. The doctor most often delivers the first diagnosis of deafness to the parents. A medical professional need not carry the entire burden of counseling the parents when his or her training has not dealt in depth with the intricacies of a hearing handicap. The parents may be referred to competent audiologists and to those speech and hearing centers that specialize in serving deaf clients. Without referral, the parents may miss the support or training they need to cope with a deaf child. This can cause growing hardships for all, especially the developing deaf child.

Professional persons, agencies, organizations and advocates should be aware of all handicapped persons and the particular problems their handicaps present. Just as important is the openness of agencies and public-service persons to creative solutions to some of the problems that would lessen the unnecessary public-created barriers.

Take deafness, for example, a service or health agency can provide services more beneficially with an awareness of how the deaf condition has manifested itself. Knowing this, we can focus on the number one hardship for deaf persons—the problem of communication with hearing persons. For an agency to serve a deaf person who became deafened in adulthood, the solution might be captioning some films, producing more printed materials, giving slower presentations or explanations, or communicating through writing on blackboards, overheads, or personal note writing as the situation indicates. Such visual modes will also help a pre-lingual deaf person, however, if English grammar is confusing to some deaf persons, information may need to be simplified. Of greatest benefit for the majority of the pre-lingual or pre-vocational deaf population (and to some later-in-life deafened individuals), however, would be information expressed in the deaf person's most natural and easily understood language—the language of signs, the language the majority of deaf adults use.

For persons who believe lipreading to be a favorable mode of communication for most deaf persons, it should be noted that 50% of our English language is hemopheneous and a person is generally only able to grasp about 30% of the words he sees spoken in a regular conversation. Short commands, or "yes" and "no" responses are most likely to be understood, but the ma-

jority of deaf persons get little or no information from lipreading regardless of the intelligence level.

Another illustration of the communication dilemma is possible by imagining the English-speaking person in a foreign-speaking country. One would become frightened to go to a doctor with a critical medical problem if unable to explain the pain or to understand the diagnosis or treatment plan. One could become irritated if in a work situation one could not communicate with a boss or socialize with co-workers. If in this isolated situation just one person cared enough to try to slow down and perhaps learn some English words to communicate with this foreigner, it would bring such relief.

The deaf person in the real world must be assisted in bridging the communication gap. English is a distorted and difficult language for a person who never hears it repeated at all or repeated enough to be comfortable with the various grammatical structures and vocabulary. And when the mouthed movements are so difficult to differentiate, the problem compounds. Thus, an agency needs to consider either hiring an interpreter when needed or training a staff member in basic sign language skills. Once the word is "out" that an agency can communicate more effectively, that agency may likely see an increase in deaf persons seeking services. Physicians, hospitals and all health-related agencies need the special sensitivities and skills to serve their deaf patients effectively.

For more information or assistance contact: Eloise Lietzow, Director, State Service Program for the Deaf, Iowa State Department of Health, Lucas State Office Building, Des Moines, Iowa 50319, telephone 515-281-3931.

DIRECTOR OF HEALTH SERVICES NEEDED AT CORNELL COLLEGE

PHYSICIAN: Cornell College is seeking a Director of Health Services. Located on a beautifully wooded and hilly campus in the community of Mount Vernon, Iowa, Cornell offers an academic and peaceful living environment. Mount Vernon has an excellent public school system and is 19 miles from the outstanding medical facilities of the University of Iowa and 19 miles from Cedar Rapids. The Director and three nurses are responsible for administering a health care program for a student population of approximately 1000 students in a modern Health Center. There may be an opportunity to join with a community physician or the physician may establish his/her own practice. In addition to a modest salary and insurance coverage, Cornell will furnish the physician with a very nice home.

Contact Dr. James Kauffman, Vice President, Cornell College, Mount Vernon, Iowa 52314 (319/895/8811).

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Morbidity Report for March, 1976

Disease	Mar. 1976	1976 to Date	1975 to Date	Most March Cases Reported From These Counties
Amebiasis	1	13	4	Boone
Ascariasis	2	6	4	Marshall
Chickenpox	2108	5709	4078	Dubuque, Linn, Shelby
Conjunctivitis	301	836	397	Scattered
Erythema infectiosum	31	63	63	Scattered
Gastrointestinal viral inf.	3910	13196	11050	Linn, Polk, Scott
Giardiasis	2	11	3	Chickasaw, Polk
Hepatitis				
A (Infectious)	23	43	57	Scattered
B (Serum)	7	21	19	Scattered
type unspecified	2	7	7	Scattered
Histoplasmosis	4	6	9	Clinton, Johnson, Lucas, Mahaska
Impetigo	94	324	215	Black Hawk
Infectious mononucleosis	107	370	470	Johnson, Polk, Scott
Influenza, lab confirmed	55	110	162	Scattered
Influenza-like illness	15878	32173	31889	Johnson, Polk
Meningococcal meningitis	2	8		Cerro Gordo, Clay
Meningitis, bacterial	1	2	5	Chickasaw
due to *H. influenzae*	2	3	4	Clinton, Muscatine
due to *D. pneumoniae*	1	1		Howard
due to *E. Coli*	1	2		Black Hawk
Mumps	294	701	419	Black Hawk, Polk, Scott
Pediculosis	50	176	121	Scattered
Pertussis	1	3	1	Johnson
Pinworms	2	9	11	Johnson, Polk
Pneumonia	186	464	444	Scott
Rabies in animals	12	21	21	Scattered
Reye's Syndrome	1	2		Poweshiek
Rheumatic fever	1	3		Mitchell
Ringworm, body	34	102	96	Scattered
Scabies	109	251	136	Scattered
Streptococcal infections	2399	7274	3818	Johnson, Polk, Scott
Toxoplasmosis	1	2		Black Hawk
Trichuriasis	2	3	1	Marshall
Tuberculosis				
Total ill	12	31	16	Scattered
Bact. positive	11	26		Scattered
Venereal diseases				
Gonorrhea	468	1641	1457	Black Hawk, Linn, Polk, Scott
Syphilis	22	95	74	Scattered

Laboratory Virus Diagnosis Without Specified Clinical Syndrom
Cytomegalovirus 2; Eaton's agent infection 1; Herpes simplex 2
Herpes zoster 1

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Medical Assistants

by TENORA MEYER, CMA

FROM VICE PRESIDENT JEANNE

Jeanne Green, CMA-A, medical assistant, Davenport, Iowa, and national vice president, has prepared the following message:

"I want to tell you what is in your AAMA membership for you—*to tell you what AAMA has done for you.*

"As a member, you are doing business with a young, but well-established organization. What were the four goals of our founders?

"First, to inspire its members to give honest, loyal and efficient service to the profession and to the public which they serve. Second, to strive at all times to cooperate with the medical profession in improving public relations. Third, to provide educational services to increase the knowledge and professionalism of its members and to stimulate a feeling of fellowship and cooperation among its societies. Fourth, to encourage and assist all unaffiliated medical assistants in forming local chapters and state societies.

"AAMA has centered its existence around these goals. Programs might never have been developed unless a national organization had, first of all, recognized the need for them, and second, 'put the wheels in motion.'

"Your association gives you two items you cannot receive or achieve in any other way: First, it has given you a name—*Medical Assistant.* Before AAMA was founded, we were called by a variety of names—receptionist, nurse, lab girl, secretary, or 'Girl Friday'; and this profusion of names created confusion as to our identities. But now, thanks to the constant efforts of our national association, we know who we are—and, more important, so do others! With this identification comes another dividend—*prestige.* For the first time, the girl who answers the physician's phone is not just office help. She is a full-fledged member of the health care team—a professional person. This did not happen overnight, and neither was it achieved through wishful thinking. It has taken years of hard work.

"For those who are not members of AAMA, I should like to tell you of our background. The first annual meeting was in San Francisco in 1957, with 17 affiliated states, and the endorsement of the AMA. In Louisville, October, 1975, the 48th state received its charter. There are over 500 component chapters with more than 16,000 members. Our executive office, in Chicago, is staffed by our executive director, Mrs. Dene R. Murray, and a dedicated group of people without whom we could not have progressed so rapidly. We have a scholarship fund available to those interested in medical assisting; a certification loan fund, so medical assistants can secure monies for the application and examination fee when they take the examination; we have a bi-monthly professional journal; and we have received commendations from AMA yearly. In 1969, the 'Essentials of an Accredited Educational Program for Medical Assistants' was approved by the AMA Council on Medical Education and AMA's House of Delegates. In 1973, the U. S. Office of Education recognized the AMA/AAMA accreditation program for medical assistant education. We have just released the first segment of our Guided Study Program, which, after many years of research and evaluation, we feel will be beneficial to all who are interested in self-improvement. We have over 2,000 certified medical assistants, and in 1975 more than 1,000 sat for the examination. We are an organization of learning and of service, service to the patient, the doctor, and the community."—JEANNE D. GREEN, CMA-A

About IOWA Physicians

Dr. David Gordon, Des Moines cardiologist, recently conducted a continuing education course in cardiology for members of Boone County Medical Society. . . . **Dr. Chauncey E. Heffernan,** Sioux City, has been named a fellow of the American Academy of Family Physicians. . . . **Dr. W. F. Brinkman,** retired Pocahontas physician, recently celebrated his 90th birthday. . . . **Dr. Herbert Gude,** Iowa Falls, discussed breast cancer at a Cancer Workshop in Iowa Falls, sponsored by Ellsworth Community College and American Cancer Society.

Dr. M. C. Jones, Boone, was guest speaker at recent meeting of Boone First United Methodist Women. Dr. Jones discussed breast cancer and the mammography diagnostic exam. . . . **Dr. R. W. Linthacum,** Dysart, will join **Drs. Robert Downie** and **Norman Westhoff** this summer in a new three-doctor clinic in Traer. . . . **Dr. Kingsley B. Grant,** Cedar Rapids, has been named director of the Department of Pathology and Laboratory Services at Cedar Rapids' St. Luke's Hospital. Dr. Grant is also a clinical assistant professor of pathology at U. of I. College of Medicine. . . . **Dr. Howard G. Beatty,** Creston, recently attended a seminar on "Cancer: Chemotherapy" at Research Medical Center in Kansas City, Missouri. . . . **Dr. John Castell,** longtime Fairfield physician, has moved to Berryville, Arkansas. A graduate of U. of I. College of Medicine, Dr. Castell practiced family medicine in Fairfield 36 years before retiring in 1972. . . . **Dr. J. J. McElwain** has opened new practice of obstetrics and gynecology in Burlington. Dr. McElwain received the M.D. degree at Marquette University and completed his specialty training at Baylor University Texas Medical Center in Houston, Texas. . . . **Dr. M. Patricia Phelan,** Altoona, has been installed as the first woman president of the medical staff at Mercy Hospital in Des Moines. **Dr. Marvin Silk** is president-elect; and **Dr. Abraham Wolf,** secretary-treasurer.

Dr. Max C. Napuli has closed his pediatric practice in Keokuk and relocated in Marshalltown where he will be associated with **Dr. Franco L. Chua** at Medical Surgical Clinic Associates, Inc. . . . **Dr. James Gannon,** Laurens, has been reappointed by Governor Robert Ray to the Board of Examiners for Nursing Home Administrators. Dr. Gannon is serving his sixth year on the Board. . . . **Dr. Warren J. Nash,** Waterloo, was presented the "Outstanding Citizen Award" by Payne A.M.E. Church in Waterloo. The presentation was made in observance of Black History Month. Dr. Nash has been in medical practice in Waterloo for 23 years. . . . **Dr. William Kuehn,** Clarinda, was a panel participant at local workshop on "Legal Aspects of Health Care." Workshop was sponsored by Iowa Western Community College. . . . **Dr. Steven Morrison** has joined **Drs. Carlyle Moore** and **Donald Hurlbut** in Emmetsburg. Dr. Morrison received the M.D. degree at U. of I. College of Medicine; interned at County Hospital in San Bernardino, California; and completed his residency in Family Practice at County Hospital in Ventura, California.

Dr. Dale A. Harding, Eagle Grove, was guest speaker at public meeting in Eagle Grove sponsored by Iowa Schizophrenia Association. Dr. Harding's topic, "Treat Schizophrenia? Is It Worth the Effort?" . . . **Dr. Richard McKay,** Waterloo, was re-appointed chairman of the medical advisory committee of the Iowa Society for the Prevention of Blindness at organization's recent annual meeting in Des Moines. . . . **Dr. F. Eberle Thornton,** Spencer, was guest speaker at annual spring meeting of school and public health nurses from nine counties in northwest Iowa. Dr.

Thornton spoke on "Identification, Management and Nursing Follow-up of Scoliosis in the School Age Child." . . . **Dr. Robert Field,** Des Moines, was guest speaker at recent meeting of Dallas-Guthrie County Medical Society. Dr. Field's topic was "Gynecological Office Procedures." . . . **Dr. George Spellman,** Sioux City, has been recognized for services to the cause of mental health. Dr. Spellman received a certificate from the Community Mental Health Centers Association of Iowa. . . . **Dr. and Mrs. Glen Kimball,** Waverly, recently spent two weeks at the Public Health Service Indian Hospital, located on the Navajo Indian Reservation at Fort Defiance, Arizona. Dr. Kimball administered anesthesia in the hospital and Mrs. Kimball, a registered nurse, worked as a Pediatric Nurse Practitioner in the homes of the Indians.

Dr. R. J. Fisch, longtime LeMars physician, retired from active practice in March. Dr. Fisch received the M.D. degree at Creighton University School of Medicine in 1931 and began his medical career in LeMars in 1935. . . . **Dr. L. W. Porter,** Indianola, will become associate medical director at Equitable of Iowa in Des Moines on September 1 and will discontinue his medical practice in Indianola. Dr. Porter recently completed a four-year term as chief of family practitioners at Iowa Methodist Medical Center. . . . **Dr. Henry M. Perry,** Bloomfield, spoke on "Cancer of the Rectum and Colon" at a meeting in Mt. Pleasant sponsored by Henry County Veterans of Foreign Wars Auxiliary. . . . **Dr. Jeffery McCullough,** professor of laboratory medicine at University of Minnesota, spoke at a recent meeting of the Wright County Medical Society. Dr. McCullough is chief director of the University of Minnesota Blood Bank and the St. Paul Regional Red Cross Blood Center. . . . **Dr. Don E. Boyle,** Sioux City, was a program participant at meeting of American College of Surgeons Committee on Trauma in Tampa, Florida. Dr. Boyle spoke on "Management of Emergency Medicine in the Small Urban Community."

Dr. Richard Kerber, associate professor in Department of Internal Medicine at U. of I. College of Medicine, has been named to the American College of Cardiology Board of Governors. . . . **Dr. Dale Christensen,** Lake City, was guest speaker at a district meeting of Iowa Nurses Association. Dr. Christensen spoke on child abuse. . . . **Dr. William Catalona,** Muscatine, spoke on arthritis at public meeting co-sponsored by Muscatine Retired Teachers Association, the Muscatine Commission on Aging and the Muscatine Community College. . . . **Dr. Theodore Roman,** a thoracic and cardiovascular specialist, and **Dr. Jitendra Kothari,** an orthopedic surgeon, joined Waterloo Surgical and Orthopedic Associates March 1. Dr. Roman received the M.D. degree at Columbia University, New York City, and completed his surgery residency at Mayo Clinic, Rochester, Minnesota. He completed a thoracic and cardiovascular residency at University Hospitals, Iowa City, late last year. Dr. Kothari, a native of India, received his medical education at Baroda Medical College; interned at Cook County Hospital, Chicago, and served his orthopedic residency at St. Francis Hospital in Wichita, Kansas. . . . **Dr. Walter G. Dennert,** Boone, and son, Richard, returned recently from a short term medical mission to Honduras sponsored by the Medical Group Missions program of the Christian Medical Society. . . . **Dr. A. Curtis Hass,** Cedar Rapids, **Dr. Benjamin J. Broghammer,** Mason City, **Dr. Kenneth D. Dolan,** Iowa City, and **Dr. William N. Cohen,** Iowa City, were named Fellows of the American College of Radiology at recent annual meeting of the College in Washington, D. C.

CONTINUING EDUCATION COURSES & CONFERENCES

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

May 9-16	Head and Neck Oncology	June 7-9	American College of Physicians Refresher Course
May 14-16	Fifth Annual Dialogue for Physicians and Hospital Administrators, Des Moines	June 7-11	Intensive Course in Pediatric Nutrition
May 20-22	Iowa Eye Association	June 9-11	Research Workshop in Immunology of Urological Cancer

Dr. R. B. Widmer, associate professor in department of family practice at U. of I. College of Medicine, participated recently in the 29th AMA National Conference on Rural Health in Phoenix, Arizona. . . . **Dr. and Mrs. Richard Jenkins,** Iowa City, were guest speakers at Algona meeting on juvenile justice. Dr. Jenkins is a child psychiatrist and his wife is noted in child development, family and human relations. . . . **Dr. Ron Flory,** former Grundy Center physician, has joined **Dr. Ronald R. Roth** in family practice in Waterloo. In Grundy Center, Dr. Flory was associated with **Dr. Patricia Ehrich** at the Family Clinic in Grundy County Memorial Hospital. . . . **Dr. Charles S. Fail,** Adel, was presented a special community service award at annual Farmer-Businessmen's Banquet. Dr. Fail has practiced medicine in Adel since 1936.

Dr. Russell E. Schurtz, Mason City, was guest speaker at recent meeting of Wright County Medical Society. Dr. Schurtz spoke on "Disease of the Ear in Children." . . . **Dr. Robert Hardin,** professor of internal medicine at U. of I., has been named president of Johnson County's United Way. Dr. Hardin was chairman of the 1976 campaign. . . . **Dr. William S. Thoman,** Sioux City radiologist and president of the Iowa Chapter, American College of Radiology, presided at recent Continuing Education Course sponsored by the Iowa Radiological Society and U. of I. College of Medicine. Speakers included **Drs. James H. Christie, Kenneth D. Dolan, Rolf L. Schapiro, William N. Cohen, Louis S. Parvey** and **Stephen E. Cornell** from U. of I. College of Medicine, **Dr. Louis Maher,** Des Moines, and Sioux City physicians, **Drs. Olaf E. Selander, Thomas Ware** and **Don Schenk.** . . . Five Iowa doctors were presented special Team Doctor awards at recent Boys' State Basketball Tournament in Des Moines. Honored for their aid to local athletic programs were—**Dr. Frank McKean,** Allison, **Dr. Enfred Linder,** Ogden, and **Drs. Paul Wolpert** and **Leo Gaukel,** Onawa, and **Dr. John Royer,** D.O., Woodward. Nominations for the award were submitted by member schools of the Iowa High School Athletic Association. . . . **Dr. H. N. Basu,** Waterloo, was guest speaker at recent meeting of Emergency Department Nurses Association at Waterloo's Allen Memorial Hospital. Dr. Basu spoke on "The Unconscious Patient."

DEATHS

Dr. Dennis H. Kelly, 78, widely known Des Moines pediatrician, died March 29 at Iowa Methodist Medical Center. Dr. Kelly received the M.D. degree at Northwestern University School of Medicine; interned at Cook County Hospital in Chicago, Illinois; and served his pediatric residency at Children's Hospital in Boston, Massachusetts. Dr. Kelly began his pediatric practice in Des Moines in 1928 with Dr. Lee Forrest Hill, retiring in 1955 because of a heart ailment. He was on the staff of Raymond Blank Memorial Hospital for Children from its founding in 1943 until his retirement. During his retirement years, Dr. Kelly was scientific editor of the JOURNAL OF THE IOWA MEDICAL SOCIETY. He served in both world wars. In 1967, he received the annual award of merit of the Iowa Medical Society. In 1968, Grinnell College awarded him an honorary doctor of science degree. In 1970, he was the recipient of the Ben Whittaker Award of the Interstate Postgraduate Assembly. He was a member of Phi Beta Kappa and Alpha Omega Alpha, American Society of Pediatrics and life member of the Iowa Medical Society.

Dr. Herman J. Smith, 70, medical director of Iowa Lutheran Hospital, died at his home in Des Moines on April 7. Dr. Smith received the M.D. degree at U. of I. College of Medicine. An internist in private practice for many years, Dr. Smith was president of the Iowa Methodist Medical Center medical staff in Des Moines from 1956 to 1957. Dr. Smith was an active participant in the Iowa Medical Society, including service as speaker of the IMS House of Delegates, IMS treasurer and Iowa delegate to the American Medical Association. At the time of his death, Dr. Smith was a member of the AMA Council on Constitution and Bylaws. He was a member of the scientific editorial panel of the JOURNAL OF THE IOWA MEDICAL SOCIETY. He served for many years as medical consultant to the Iowa Selective Service. He was a past president of the Iowa Clinical Society and a fellow of the American College of Physicians. He was a member of Phi Beta Kappa, Sigma Xi and Alpha Omega Alpha fraternities.

Dr. Thomas G. Wellman, 63, Clinton, died February at Methodist Hospital in Rochester, Minnesota. Dr. Wellman received the M.D. degree at the University of Minnesota Medical School in 1936. He interned in Jersey City, New Jersey and completed postgraduate work at Mayo Clinic in Rochester, Minnesota and the University of Mexico.

Dr. George Braunlich, 85, Davenport physician for 40 years, died February 12 at Ridgecrest Health Wing in Davenport. Dr. Braunlich received the M.D. degree at Johns Hopkins University in Baltimore, Maryland. He located in Davenport in 1915 and retired in 1955. Dr. Braunlich was a past president of the Iowa-Illinois Central District Medical Association and past president of Scott County Medical Society. In addition to his medical career, Dr. Braunlich was former treasurer of the Brammer Manufacturing Company and president of the Davenport Machine and Foundry Co.

Dr. William B. McTaggart, 73, longtime Fort Dodge physician, died February 22 in West Des Moines. Dr. McTaggart received the M.D. degree at Creighton University Medical School and served his internship at St. Mary's Hospital in Hoboken, New Jersey. He began his practice of medicine in Fort Dodge in 1944, retiring in 1975.

Dr. Allen J. Ryan, 71, died February 7 in Madison, Wisconsin. Dr. Ryan received the M.D. degree at Creighton University School of Medicine and practiced in Harlan and the Monona areas for many years.

Dr. George C. Scanlan, 75, DeWitt, died March 19 at Mercy Hospital in Clinton. Dr. Scanlan received the M.D. degree at Creighton University Medical School and was honored last year as a 50-year graduate. He interned at Mercy Hospital in Davenport and began his medical practice in DeWitt in 1926. Dr. Scanlan also taught at Creighton University and was on the staff at Veteran's Domicillary in Clinton and Iowa Veterans Home in Marshalltown, retiring in 1969. He was a life member of the Clinton County Medical Society.

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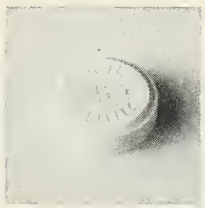

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President's Page

Now here is a new name and a new face—maybe after all these years not so new but at least different. Last year it was Verne Schlaser and next year it will be Bill Swanson. It matters little who is president one year or another but the Society itself matters greatly.

It matters greatly that the Iowa Medical Society shall endure and grow in service, size, and strength. We must preserve its tradition of service with unremitting efforts to provide the ill and injured of Iowa the most modern medical care in ample supply. We must increase our size and strength by adding to our numbers those colleagues still outside our ranks. We must not become paranoid about criticism but must view ourselves as calmly and dispassionately as we add up a presenting set of symptoms and findings.

James F. Bishop, M.D.

James F. Bishop, M.D., President

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Iowa Swine-Like Influenza Immunization Plan

More than 200 million Americans will be vaccination targets this summer and fall in an unprecedented effort to protect the population from a potential threat represented by the widely-publicized swine-like flu virus. The federal government has allocated $135 million to purchase vaccine for individual state use.

Nationally, the American Medical Association has endorsed the project. It has issued this statement:

The American Medical Association supports the decision of President Ford to undertake a massive national immunization campaign against the swine-like influenza virus. Under the circumstances, we believe his decision is absolutely the correct one.

The AMA stands ready to assist in the national campaign in any way possible, including organizing the medical profession to insure that every person who wants to be vaccinated will be—regardless of ability to pay.

We speak for the medical profession in committing the doctors of this nation to make whatever efforts are necessary to vaccinate the entire population. It will not be easy, but it can and must be done.

An Iowa program has been in the planning process for several months. A special committee of the Iowa Medical Society has met several times with State Department of Health officials to devise the three-phase blueprint described here. This plan has been presented to the Iowa Medical Society Executive Council and House of Delegates. The House of Delegates approved the following resolution on May 2:

Resolved, That the Iowa Swine Influenza Immunization Plan be approved by the Iowa Medical Society, subject to local modification and adaptation to more effectively serve the county or community involved.

As noted in the action of the House, the vaccination program may be pursued in the manner a county determines to be most effective. State Department of Health representatives are meeting with persons in each county to assist with planning activities. The IMS special committee is also available to provide counsel if requested.

THIS INTENSIFIED IMMUNIZATION program will have as its goal the prevention of morbidity and mortality from influenza in Iowa during winter 1976-77. The participation and cooperation of many individuals (particularly Iowa physicians) and organizations (including the Iowa Medical Society) will be needed to achieve the goal.

The project is planned as a three-phase, highly-visible effort combining the time, expertise and facilities of individuals and agencies from both the private and public health sectors. A prephase segment of the plan will be undertaken to reach that portion of the population which is aged and/or chronically ill.

The plan described here will be presented to appropriate health officials (including those of the county medical society) in each county by representatives of the State Department of Health. It will be the intention of the SDH representatives to outline the plan, offer assistance as desired, and become familiar with any alternate approaches which may be devised locally. The chairman and members of the special committee of the Iowa Medical Society will make themselves available as possible to provide requested medical expertise. Please direct inquiries to the Iowa Medical Society Headquarters.

PREPHASE (BIVALENT VACCINE)

It is expected that between 300,000 and 350,000 doses of bivalent vaccine (A Victoria and A Swine) will be available in Iowa by mid-July. This will be administered to aged and debilitated persons. Through the cooperation of the Health Facilities Association of Iowa and other agencies, the residents of nursing homes and other congregate living facilities for the elderly will be immunized with this vaccine; there are about 37,000 individuals in this category.

The method of vaccine distribution, as it will be in Phase One, calls for the SDH to provide a supply to the pharmacies of all Iowa hospitals. From there, private physicians may obtain, themselves or by their authorized representatives, the amount of vaccine they anticipate they will need to provide coverage for the aged or ill under their care.

The determination as to who will receive this bivalent vaccine, outside of the residents of nursing homes, will be left essentially to physicians. This advance program will not be advertised as being available to the general public. More complete details on the prephase segment of the program will be set forth in a letter from the SDH to physicians, operators of health care facilities, etc.

PHASE ONE (THE PRIVATE SECTOR)

Two shipments of monovalent vaccine are expected to reach Iowa in August totalling approximately 2.5 million doses. The distribution of this vaccine by the SDH also will be to the pharmacies of Iowa hospitals.

The first target group to be vaccinated with this supply will include those in the health care field and those in other essential community services.

Next, it is hoped the major thrust of Phase One will proceed with the providers of health care (receiving leadership and direction from the county medical societies) mobilizing to provide a highly-concentrated, highly visible opportunity for residents of a county to become vaccinated. It is hoped and recommended the date of Saturday, September 11, 1976, be used by physicians to initiate or offer entirely a significant private sector vaccination effort.

Each county will need to decide the exact manner in which it desires to conduct the private or Phase One element of the total program. In many instances, hopefully, the election will be made by physicians and clinics to open their facilities on the particular day (September 11) and/or other days selected to administer the vaccine to all regular patients and to others who appear to obtain protection in this manner. In some counties or communities, a determination may be made to conduct this phase at one or more hospitals or in some other appropriate community facility.

While SDH officials and others will be available to assist and counsel in this Phase One effort, the private sector will be largely responsible for its planning and execution. Now being organized is a coordinated program involving the Iowa Medical Society Auxiliary (and its osteopathic counterpart), the Iowa Federation of Women and the Jaycees. It will be the purpose of this program to obtain names of volunteer nurses and other health care and clerical personnel and arrange for their presence at local sites where their services are needed.

Use of the September 11 date by the local medical community will benefit from any statewide publicity which is issued. However, if for good reason, another date or dates are selected, assistance will be provided by the SDH in publicizing those special private sector efforts arranged by a particular county.

PHASE TWO (THE PUBLIC EFFORT)

Subsequent to the concentrated private effort (presumably in the concluding weeks of September), the public health resources of the SDH and those at the community level will offer swine-like influenza vaccine through schools, other institutional settings, public health clinics and in other prudent ways. It is expected that 10 qualified two-man jet injector teams from the SDH will assist local personnel in the seven most populated areas, i.e., Des Moines, Davenport, Sioux City, Cedar Rapids, Waterloo, Council Bluffs and Dubuque. The 450 school nurses and 225 public health nurses will supplement this effort in these and the remaining 92 counties.

In conjunction with the school and institutional aspects of Phase Two, it is expected that Sunday public immunization clinics will be conducted on September 19 and 26 in at least five locations in the Des Moines area and one each in the remaining six metropolitan areas. Additional Sunday clinics may be undertaken in the remaining

counties depending upon the need and desires of local officials. It is obvious that support, advice and personal participation will be required of some physicians in the public or Phase Two portion of the campaign. An assessment of the state situation will be made in the last few days of September to determine the magnitude and direction of Phase Three.

PHASE THREE (CLEAN-UP EFFORT)

The month of October will be devoted to reaching by whatever means are decided those individuals who remain unvaccinated. In their offices and clinics, physicians may wish to remind patients of the need for the vaccination by a sign, a mailing, etc., and allow specific times during the month for the administration of vaccine to persons requesting it. Obviously, the vaccine will be available to physicians all through September and October for this purpose.

SDH personnel will continue to be available through October to work with and assist those counties and communities that wish and need to raise their immunization levels. It is hoped by the end of October and the onset of the flu season a major portion of the state's population will be protected.

MATTER OF ECONOMICS AND INFORMATION REPORTING

The question of payment for the vaccine and its administration is a difficult one in the instance of this unique program. The matter has been discussed at length on several occasions. At this point, the hope is that uniformity may prevail so that individuals will participate on the same basis regardless of where and when they obtain the vaccination.

To this end, it is recommended that a one dollar donation be requested for each individual immunized, but that no person be turned away for inability to donate one dollar. In instances where private physicians, individually or banded together, give the vaccinations, the one dollar donation will be retained to help defray the cost of materials and the payment of personnel where this is necessary. One dollar donations received at the public clinics will be transferred to the state treasury to help offset a possible special state appropriation provided to meet state expenses. Any balance will probably be returned to the state fund.

When obtaining the vaccine physicians will be required to certify to two things: first, that they will make no charge for the vaccine itself, and second, that they will report by age category the individuals to whom the vaccine is administered. The SDH expects to have forms available which will facilitate these requirements.

It is recognized that physician charges for the administration of the vaccine will be for individual determination. The recommendation of a one dollar donation is offered for consideration by physicians and county medical societies in the interest of (1) uniformity, and (2) the beneficial reflection it will have on the medical profession.

SCIENTIFIC ASPECTS OF THE PROGRAM

The development and testing of the vaccine is now in process. Maximum effort is being made by the CDC and other branches of the federal government and the pharmaceutical industry to produce an effective and safe vaccine. The anticipated reaction rate has been estimated between 5 and 15 percent, with the majority of these restricted to a brief sore arm. Specific questions of a scientific nature may be directed to either the State Department of Health or the special committee of the Iowa Medical Society.

The subject of liability is being studied and it is possible this important element may be assumed by the state or handled in some special manner. It is well for the medical profession to know that the subject has been raised and is before state officials.

SUMMARY

Without mass immunization, government scientists warn, the nation runs a fair risk of enduring a "swine flu" pandemic several times greater than any flu outbreak in generations. Few people under 50 years of age have any natural antibodies, and the population is nearly universally susceptible. Against this kind of backdrop, the special IMS Committee on the National Swine Virus Vaccination Program believes the Iowa medical profession must be willing to contribute the time and knowledge necessary to safeguard the population to the fullest extent possible.

MEDICAL MISCELLANY

(Continued from page 201)

AWARDS . . . Herman J. Smith, M.D., Des Moines, received posthumously the 1976 Merit Award at the May 1 Delegates' dinner. Other recognition included: Ben T. Whitaker Teaching Award—D. G. Sattler, M.D., Kalona (for long and distinguished service in the preceptor program); John F. Sanford Award—Mrs. Joyce Montag, Creston (for effective work in health planning programs); Washington Freeman Peck Award—Iowa High School Athletic Association (for support of health programs for prep athletes).

LIFE MEMBERS . . . Accorded IMS Life Membership May 1 were D. O. Bovenmyer, M.D., Ottumwa; F. C. Dunn, M.D., Cedar Rapids; O. N. Glesne, M.D., Fort Dodge; H. D. Harper, M.D., Fort Madison; J. M. Krigsten, M.D., Sioux City; E. A. McMurray, M.D., Kellogg, and H. W. Rathe, M.D., Waverly.

PROFESSIONAL LIABILITY . . . Iowa had 1.54 liability claims per 100 physicians during approximate six-month period (last half of 1975). This finding is contained in second of four quarterly reports included in a closed-claim study being made by the National Association of Insurance Commissioners. Nationally, claim level was 2.56 per 100 physicians. Iowa shows 46 total claims during the period with 27 having involved some indemnity payment; 10 exceeded $10,000. Total Iowa indemnity paid is shown as $427,525.

IMPAC CHAIRMAN . . . Thomas E. Kiernan, M.D., Newton, has succeeded Robert D. Whinery, M.D., Iowa City, as board chairman of the Iowa Medical Political Action Committee. More than 700 Iowa physicians are current IMPAC members.

SCANLON BOARD ELECTS . . . Richard Hockmuth, M.D., Iowa City, was elected May 1 to membership on the Board of Directors of the Scanlon Medical Foundation/Iowa Medical Society. Dr. Hockmuth will succeed L. H. Jacques, M.D., Iowa City, who concludes approximately 8 years of distinguished service as a Board member. A position on the Scanlon Board was also created for a representative of the IMS Auxiliary.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

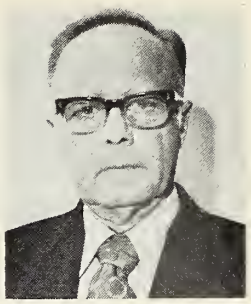
NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

The Question Box



by KENNETH E. LISTER, M.D.

JUNE STATUS OF IFMC/PSRO

The fifth anniversary of the founding of the Iowa Foundation for Medical Care is marked here with a brief status report from President K. E. Lister, M.D., Ottumwa.

Where precisely is the Foundation in its implementation of the Iowa PSRO program?

The Foundaton is in the process of evaluating review plans submitted by the hospitals to determine those eligible for "delegated status." Delegation means that a hospital has presented an acceptable plan for performing its own review activities. The selection of delegated hospitals is to be made by a committee of the Foundation Board. This committee is composed of representatives from each of the Foundation's district peer review committees. In addition, there is a representative of the Iowa Hospital Association and an osteopathic physician. The committee will coordinate its evaluation activities with the local peer review unit as it determines a hospital's eligibility for delegated status.

How many hospitals does the PSRO expect to affiliate with this year?

Earlier this year the Foundation signed a contract with HEW for over $580,000 to support PSRO efforts with approximately 50 hospitals during the first year. Since signing the contract, there have been some major changes in PSRO financing which may permit us to work with more hospitals if the implementation schedule permits. Of the 50 hospitals expected to be phased in this year, 30 to 35 will be delegated. The remainder will be non-delegated or partially delegated hospitals. In a non-delegated hospital, the PSRO is directly responsible for the local review through a system of a coordinator and local physician advisor. In a partially delegated hospital, the hospital assumes the responsibility for either concurrent review activities or medical care evaluation studies.

What new impact will PSRO have on physician members of hospital staffs where PSRO agreements are consummated?

The Foundation's plan for PSRO implementation reflects its existing structure of peer review. The Foundation will continue to stress that review be done locally by hospital medical staffs and peer review committees. The PSRO law provides that if a hospital is performing effective review, it may receive delegated status. This entitles the hospital to submit claims to the intermediary and be free from any further retrospective review of medical necessity or duration of care included on the claims. The only monitoring a delegated hospital is exposed to is a summary review by the PSRO to determine if the hospital is continuing to operate effectively. In a delegated hospital, the medical staff performs the total local review, including admission screening, concurrent review, and quality care evaluation with the assistance of the hospital administration.

What statistics offer an impression of what the Foundation is accomplishing?

The Foundation continues to peer review fee cases submitted by physicians, health insurance companies and the public. During 1975, the Foundation resolved over 1,100 cases through the peer review process, bringing the total cases resolved since the Foundation's inception to well over 3,000. There has been an increase in the number of physicians requesting peer review. This is a positive trend and hopefully will continue as physicians recognize the ability of the Foundation to resolve fee questions which may arise with an insurance company.

IN THE PUBLIC INTEREST/MALPRACTICE EDUCATION

A broader understanding of today's medical malpractice dilemma by the citizens of Iowa would be helpful. This is not meant to suggest there is no appreciation of the widely-discussed societal problem. It is meant rather to acknowledge the complexity of the subject and to admit the medical profession does have a responsibility to be about the business of public education.

This big question is *how:* how to increase the understanding of the public as to why the cost and scarcity of liability insurance for physicians is impacting on the total population. The 1976 Iowa Medical Society House of Delegates pondered the medical liability situation at length on May 1 and 2 and approved the following resolution:

Resolved, That the Iowa Medical Society give further attention to designing and implementing a public education program concerning public liability, to include consideration of contacts with the press, and that this program be pursued under the direction of the Medico-Legal Committee and the Board of Trustees.

Indeed, there has been much attention given to the medical liability phenomena through the state's news and editorial columns and the broadcast media. The Iowa Medical Society has been a regular and prominent contributor of information in this connection. The Society has considered the purchase of newspaper space and broadcast time to elaborate on the topic. And in line with the previously noted action of the IMS House of Delegates, this approach will be evaluated further.

Probably the simplest and most effective means of communications is patient-physician conversation. In a few minutes a physician can do much to help an interested patient better understand the medical malpractice situation. Talks of this type, two or three times a day, will likely do much to increase public understanding.

It is suggested that physician members of the Iowa Medical Society accept the challenge represented here—to visit with patients about this complex problem. To facilitate the opening of malpractice conversations with patients, the message which appears below has been placed on a small placard for placement in the patient reception area, on a counter, magazine table or wall. *Copies are available to interested physicians at no charge. Please call or write the Iowa Medical Society if you desire one or more copies.*

TO MY PATIENTS—A WORD ABOUT MEDICAL MALPRACTICE

Medical liability (or malpractice) is a term we Iowans have heard often this past year or so. It's my responsibility, as your doctor, to help you understand why Iowa has a medical liability problem of near-crisis proportion. We all need to be concerned about this matter—for two basic reasons:

- The strong impact it's having on the cost of medical services.
- The threat it represents for reduced availability of medical services.

The cost of health care has risen steadily. Sharply increased liability premiums are one reason why. Neither your physician nor your hospital can control these costs when they are required to pay exorbitant liability insurance premiums. An end to this cost spiral is not yet in sight.

Young doctors facing high malpractice insurance premiums upon entry into practice are uncertain of their situations. Older doctors are considering early retirement or are switching to less risky insurance categories.

The picture is indeed a serious one. Solutions have been offered by the medical profession and others. Some state legislation has been enacted. This has all been productive to a degree. But additional action is needed.

Please feel free to discuss the medical malpractice problem with me. I will be glad to allow a few minutes for this purpose.

SCIENTIFIC ARTICLES

Current Management of Preeclampsia and Eclampsia

JAMES R. SCOTT, M.D.
Iowa City

An understanding of pathophysiologic changes must exist to manage preeclampsia and eclampsia. To handle this disease effectively, the severity must be assessed, hospitalization should be undertaken and delivery planned.

ALTHOUGH LESS COMMON than in certain other parts of the United States, there are still several maternal deaths in Iowa each year which result from toxemia of pregnancy or its sequelae. Approximately 5-7% of all deliveries at University of Iowa Hospitals each year are complicated by preeclampsia, but because of a different patient population the incidence at most private hospitals in the area is closer to 2-3%. Since individual physicians see patients with severe preeclampsia or eclampsia only infrequently, there is a natural tendency to become complacent about the disorder. Nevertheless, the development of severe toxemia can result in a disastrous pregnancy outcome. This means each physician doing obstetrics should be familiar with the disease and its management.

Dr. Scott is an associate professor in the Department of Obstetrics and Gynecology at the University of Iowa College of Medicine.

ETIOLOGY

The cause of preeclampsia or pregnancy induced hypertension remains unknown. A possible immunologic etiology is currently in vogue but not proven.[1] Recent studies have shown that a variety of physiologic aberrations in primigravidas precede the development of overt hypertension by many weeks. For example, with the discovery that the renin-angiotensin system is involved in blood pressure regulation and the development of hypertension in the non-pregnant state, it was inevitable that the dynamics of this system would also be studied in pregnancy. In normal human pregnancy, increased amounts of infused angiotensin II are required to elicit a normal pressor response. Conversely, in pregnancies complicated by preeclampsia, smaller amounts of infused angiotensin II are required to raise the diastolic blood pressure. These differences in pressor response to infused angiotensin II between primigravidas with normal pregnancies compared with those destined to develop preeclampsia have been observed as early as 24 weeks gestation.[2] In fact, this test accurately forecasts which primigravidas will eventually develop preeclampsia. Unfortunately, it is not clin-

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF JUNE, 1976.

TABLE I

1. Gravida I patients, 28-32 weeks gestation, are candidates for the roll-over test.

2. The patient should lie quietly on her left side. The blood pressure should be repeated every five minutes for 15 minutes or until a stable baseline diastolic blood pressure is achieved.

3. The patient is then rolled over onto her back and the blood pressure is repeated immediately. Repeat the blood pressure one more time for confirmation.

4. The results of the roll-over test should be recorded on the prenatal record progress notes. Example, *roll-over test*—Side: 90/50, Back: 110/70. A rise in diastolic pressure of 20 millimeters of mercury or more is a positive roll-over test.

5. A patient demonstrating a positive roll-over test should be reappointed for one week. The roll-over test should be repeated and if still positive the patient is at high risk for the eventual development of pregnancy induced hypertension.

ically useful since (a) there is a limited supply of angiotensin II, (b) the procedure is expensive and time consuming, and (c) it is not universally available. More recently, a practical clinical test was observed to correlate closely with the results of the angiotensin pressor test.[3] Specifically, an elevation of diastolic blood pressure of 20 mm Hg or greater was noted in patients later to become preeclamptic after they were turned from the lateral recumbent to the supine position. The same position dependent change in diastolic blood pressure was not observed in those subjects who remained normotensive throughout pregnancy. The "Roll-Over" test reportedly detects about 90% of patients who will eventually develop pregnancy induced hypertension and is performed as outlined in Table I.

PREVENTION

Even if it is possible to predict which patients will develop preeclampsia, is there any effective method of prevention? Or once signs and symptoms are present, is the process reversible? A variety of preventive measures have been advocated as follows:

A. *Weight Restriction*—The theory that toxemia was caused by excessive weight gain stems from a reported reduction in the incidence of toxemia in Germany and Austria during World War I, when food scarcity led to lesser weight gain during pregnancy. However, most of these women were multiparous and not at high risk for the development of preeclampsia. More recent studies have concluded there is no evidence prescribed caloric restriction during pregnancy has any effect on the incidence of toxemia or that women with excessive gain in fatty tissue are more likely to develop toxemia.[4] To the contrary, there is evidence diet restrictions may be detrimental and contribute to the incidence of low birth weight infants.

B. *Diuretics*—Although diuretics have been used widely to prevent toxemia, double blind studies[5] have shown no difference in the incidence between treated and untreated groups. Moreover, thiazide diuretics can induce serious depletion of both sodium and potassium, leading eventually to water intoxication especially in patients whose labors are induced with oxytocin, and further deplete the already decreased plasma volume in these patients. Diuretics have also been shown to decrease both the plasma conversion of dehydroisoandrosterone sulfate to estriol by the placenta and glomerular filtration rate in the kidney in preeclamptic women.[6] Thus, these indicators of placental perfusion and renal function suggest that diuretics may actually be contraindicated in this situation.

C. *Hospitalization and Bed Rest*—Renal function, as determined by urinary output and a variety of biochemical renal function tests, is affected by posture during pregnancy. These parameters are consistently improved in the supine as compared to the upright position, and are further increased when the patient lies on her side as compared to lying on her back.[7, 8] Therefore, there is some scientific rationale for believing that bed rest in the lateral recumbent position increases both placental and renal perfusion, confirming the clinical impression that treatment of preeclamptic patients with enforced inactivity is beneficial to both mother and fetus.

Guidelines for hospitalization in preeclampsia are: 1) a systolic blood pressure of 140 mm Hg or above or a diastolic blood pressure of 90 mm Hg or above, 2) significant proteinuria, and 3) repeated weight gain of 3 lbs or more per week in the latter part of pregnancy. For an intelligent appraisal of the severity of the disorder in each hospitalized patient the following should be done:

1. A history and physical examination followed by the daily search for such signs and symptoms as headache, hyperreflexia, visual disturbances, and edema of the fingers and eye lids.

2. Weight on admission and every other day thereafter.

3. Blood pressure readings every four hours

TABLE II

Clinical Condition	*Therapy*
1. Eclampsia	Prevent convulsions; delivery
2. Preeclampsia with mature infant	Prevent convulsions; delivery
3. Preeclampsia with immature infant with any signs of:	Prevent convulsions; delivery
a) Severe preeclampsia	
b) Impending fetal death	
4. Mild or moderate preeclampsia with an immature infant	Expectant therapy with hospitalization

except between midnight and morning unless the midnight pressure has risen.

4. Record of daily fluid intake and urinary output.

5. Frequent quantitative analysis of urine for protein.

6. Retinal examination on admission and every few days thereafter.

7. Since hemoconcentration correlates well with the severity of the disease, serial hematocrit determinations are useful.

PROVEN THERAPEUTIC REGIMENS

Expectant therapy is indicated only in patients with mild or moderate preeclampsia who have an immature fetus. (Table II.). In retrospect, most of the serious problems in preeclampsia are due to failure to recognize the severity of the disease, failure to hospitalize the patient, or failure to deliver her. Once convulsions have occurred, the maternal mortality rate is markedly increased. Therefore, if the patient has signs and symptoms of severe preeclampsia or actually develops eclampsia, she should be started immediately on magnesium sulfate therapy and delivery should be accomplished regardless of the stage of gestation. When the disease is severe, uteroplacental blood flow is already markedly compromised preventing further fetal growth and the chance of *in utero* fetal death increases. Moreover, these chronically stressed infants have less problems with respiratory distress as compared to normal premature infants delivered at the same stage of gestation.

MANAGEMENT OF ECLAMPSIA

All obstetric units should be equipped with the supplies as shown in Table III for the emergency treatment of eclampsia.

A. *Initial Treatment*—As soon as basic diagnostic steps have been taken and any airway obstruction relieved, magnesium sulfate, 20 ml (4 gm) of a 20% solution drawn into a syringe, is slowly injected intravenously (no faster than 3 minutes accurately timed). As soon as this injection is completed, 20 ml (10 gm) of a 50% solution of magnesium sulfate is injected intramuscularly, one-half deeply through a 3 inch long needle into the upper outer quadrant of each buttock. Thus a total of 14 gm of magnesium sulfate is injected initially.

Magnesium sulfate so administered nearly always arrests the convulsions. However, very infrequently another convulsion may occur. Again, the tongue should be protected and airway maintained. If the magnesium sulfate injections had been completed 20 minutes before or less, the convulsion usually is brief and will not recur. If the interval has been much longer than 20 minutes, or if the patient convulses again, 10 ml (2 gm) more of 20% magnesium sulfate solution is again given slowly and intravenously. In the unusual circumstance in which convulsions still persist or there is marked postictal physical agitation and confusion, up to 0.25 gm of Sodium Amytal can be injected intravenously over a period of not less than 3 minutes.

As soon as it is convenient, an intravenous in-

TABLE III

SUPPLIES AND EQUIPMENT FOR EMERGENCY TREATMENT OF ECLAMPSIA

50% Magnesium Sulfate ($MgSO_4 \cdot 7H_2O$ USP) Solution
20% Magnesium Sulfate Solution
20 mg ampules of Hydralazine (Apresoline)
0.25 gm ampules of Sodium Amobarbital (Sodium Amytal)
Ampules of 10% Calcium Gluconate
Syringes (20 ml and 10 ml)
20 gauge needles (1½ inch and 3 inch)
Padded tongue blade or plastic bite stick
Oropharyngeal airway
Suction apparatus
Oxygen supply and clear plastic mask
5% Dextrose in water for intravenous infusion

Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

fusion system is established with 5% dextrose in water unless hypovolemia from hemorrhage is identified or suspected in which case Lactated Ringer's Solution is used initially. In the usual case of severe preeclampsia or eclampsia, the extracellular compartment is so expanded as to cause generalized edema. Since in such instances vigorous fluid administration is unnecessary and may be dangerous (pulmonary edema), the 5% solution of dextrose in water is given at a slow rate of 60 ml per hour or 1 ml per minute. Diuretics including furosemide (Lasix), Mannitol, or hypertonic Dextrose are *not* given either to try to mobilize edema fluid or increase urinary output. Instead a Foley catheter is inserted into the bladder and urine flow, not manipulated artificially, is used as one important indicator of the severity of the disease. Markedly decreased renal perfusion from vasospasm is reflected in oliguria and relief of the vasospasm with increased renal perfusion is reflected in increased urine flow. Diuretics increase urine excretion without necessarily increasing renal perfusion or glomerular filtration.

The blood pressure is monitored and recorded at least every 15 minutes. If unusually high, i.e., over 180/120 mm Hg, there is some danger of a cerebrovascular accident and hydralazine (Apresoline) is administered intravenously to lower the pressure to a more acceptable level but never to "normal ranges." A test dose of 5 mg is given intravenously and the blood pressure is again monitored. The desired effect is almost always achieved with 5 to no more than 25 mg of hydralazine. The duration of the effect is variable but the effective dose is simply repeated at whatever interval is necessary to prevent severe hypertension.

MONITOR FETAL HEART

The fetal heart is monitored closely. It is not unusual immediately after a convulsion for either fetal tachycardia or bradycardia to be identified. Most often these changes are the consequence of the convulsion and the hypoxia and lactic acidosis that results. Treatment for these abnormalities in fetal heart rate is *not* immediate operative intervention. Simply administer oxygen by mask with the mother in a lateral recumbent position to promote recovery from the metabolic derangement.

B. *Laboratory Studies*—These need not be extensive although the automated systems for analyses now in use encourage a variety of tests. Hemoglobin, hematocrit, white blood count, platelet count, observation of a tube of blood for clotting, and inspection of the plasma for abnormal amounts of bilirubin or hemoglobin should be carried out. Plasma cations and plasma creatinine are seldom abnormal unless the woman has previously been vigorously treated with diuretics, the disease is unusually severe, or there is underlying chronic renal disease. Urine should be checked for protein and two units of whole blood should be cross matched.

SYSTEMIC TREATMENT

C. *Subsequent Treatment*—Further systemic therapy with magnesium sulfate is essential to prevent recurrence of convulsions. Ten ml (5 gm) of 50% solution of magnesium sulfate are injected intramuscularly deeply into the upper outer quadrant of alternate buttocks *every 4 hours* after ascertaining that: 1) the patellar reflex (knee jerk) is present, 2) urine flow has been 100 ml or more during the previous 4 hours, and 3) respirations are not depressed. This regimen is continued throughout labor, delivery, and for at least the first 24 hours postpartum. If the knee jerk is not elicited, await its return before giving more magnesium sulfate. Typically the patellar reflex is lost when the plasma magnesium concentration is 7-10 mEq per liter. If urine flow is less than 100 ml per 4 hour period, withhold further magnesium sulfate until 100 ml of urine has been excreted. To minimize local discomfort in the conscious patient, 2 ml of 2% Lidocaine (Xylocaine) can be added to the syringe before injecting the magnesium sulfate solution. The advantage of the intramuscular route is that blood levels have been well studied, the dosage regimen is standardized, effective, safe for both mother and infant, and it requires reevaluation of the patient's condition every 4 hours before the next injection is given.[9, 10] However, intravenous magnesium sulfate in dosages of 1-2 gm per hour can also be used effectively as long as the patient is also constantly reevaluated for evidence of magnesium toxicity and fluid overload.

The advantages of magnesium sulfate over other drugs are that it definitely controls and prevents seizures due to toxemia, and because the patient is awake and alert in contrast to barbiturates, tranquilizers, or morphine, maternal airway problems, aspiration of stomach contents, and respiratory depression in the infant do not occur.

In the rare circumstance in which maternal respiratory depression is induced by parenteral magnesium sulfate therapy, 10 ml of a 10% solution of calcium gluconate given intravenously over 3 minutes will relieve the depression.

D. *Delivery*—Once the possibility of convulsions have been controlled in patients with severe preeclampsia or eclampsia and no other obstetric complications co-exist or develop, there is no immediate urgency for effecting delivery but neither is there reason for procrastination. As soon as her condition is stabilized, labor may be induced with carefully administered intravenous oxytocin and amniotomy. Since the uterus of a woman with toxemia may be unusually sensitive to oxytocin, the pattern of uterine contractions and the fetal heart rate must be closely monitored. Cesarean section is used only for obstetric indications such as failed induction, fetal distress during labor, or other obstetric complications.

Analgesia during labor should be limited to 50 mg of meperidine (Demerol) given intravenously at intervals of 2 hours or longer. If the fetus is premature, meperidine and similar agents should be avoided completely if at all possible. Regional anesthesia (spinal, caudal, or epidural) is contraindicated for delivery of the woman with eclampsia. General anesthesia with a small dose of sodium thiopental, nitrous oxide plus oxygen and succinylcholine can be used if needed but the amount of succinylcholine necessary for appropriate muscle relaxation is usually *less* for women who have received magnesium sulfate. This does not contraindicate the simultaneous use of these two agents; instead less succinylcholine is given.

Blood loss is commonly greater with deliveries of women with severe preeclampsia and eclampsia but at the same time the maternal blood volume is typically appreciably less than with normal pregnancy. The atonic uterus should be treated with uterine massage and intravenous oxytocin. An abrupt fall in blood pressure with delivery most often means serious hypovolemia and not immediate relief of the vasospastic state. Therefore, the oliguria from severe hypovolemia following hemorrhage should be treated with blood and not diuretics.

CONCLUSION

The modern management of preeclampsia and eclampsia is based on understanding the pathophysiologic changes that are occurring in the patient. A therapeutic plan that includes recognition of the severity of the disorder, drug treatment with magnesium sulfate, and delivery of the patient is simple and proven effective. In 155 women with eclampsia that have been treated at Parkland Hospital as outlined above, the maternal mortality rate has been zero. Moreover, all infants that were alive when treatment was started and weighed 1800 gm (4 lbs) or more have survived.[11]

REFERENCES

The references noted in this paper may be obtained either from the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

PLAN ECG IMPROVEMENTS

Rapid and highly accurate analysis of electrocardiograms received from distant points will soon be possible at University Hospitals in Iowa City. The illustration is given that an electrocardiogram taken at 11 a.m. in a community hospital will be analyzed before noon by a University cardiologist.

The speed is made possible reportedly by a computer-assisted ECG analysis system to be installed at University Hospitals. The system eventually will provide regional hospital access to computerized ECG interpretations via telephone.

Indications are the system will assist Iowa hospitals through the availability of an overread or verification of computerized reports from a cardiologist. While computerized readings have been available for some time, experience has indicated a degree of inaccuracy which is expected to be alleviated.

The University system now in the planning stage is being designed by cardiologists in collaboration with a bioengineering specialty. The system will be valuable to community hospitals lacking staff cardiologists or for use in unusual cases.

Hyponatremia In Rural Hospitals

HUBERT J. VAN PEENEN, M.D.
Decorah

Incidence of hyponatremia in three northeast Iowa hospitals has been evaluated over a 12-month period. Treatment is noted as usually successful when undertaken in a slow and deliberate fashion.

Most reports on hyponatremia come from large hospitals. Hence, only its more exotic aspects receive much emphasis. For example, there is extensive literature on the "syndrome of inappropriate secretion of antidiuretic hormone (SIADH)," even though it is a rare cause of low serum sodium.[1]

This paper adds information on hyponatremia from another source, the small rural community hospital. It shows hyponatremia is common in this setting; more frequent in the elderly; nearly always hypovolemic and associated with a failure of fluid intake, vomiting or diarrhea; and is often symptomatic, but never a cause of major morbidity or death. Its development is facilitated by the use of diuretics but they are rarely, if ever, the only cause. It is frequently unmasked by iatrogenic use of electrolyte-free intravenous solutions. It is rarely caused by SIADH or the "cerebral dilution syndromes."[2]

Dr. Van Peenen is in the private practice of pathology and is associated with the Winneshiek County Memorial Hospital in Decorah, Iowa.

Therefore, in most situations, hyponatremia should be preventable. When it occurs it can safely be repaired through slow treatment. In this way, the risk of fluid overload is eliminated. This is a not uncommon complication when correction of fluid and electrolyte imbalance is undertaken in large centers.

MATERIALS AND METHODS

Laboratory records were reviewed for the year August 1, 1974 to August 1, 1975. The participating institutions were Winneshiek County Hospital, Decorah; Howard County Hospital, Cresco; and Veterans Memorial Hospital, Waukon, Iowa. These hospitals are served by 15 general practitioners and 2 general surgeons.

The search identified 39 patients with at least one serum sodium level below 130 mEq/L. Other cases were undoubtedly missed since serum electrolytes are ordered sparingly by the attending staffs. All were white, middle class patients.

Patient charts were reviewed to obtain the following data:

1. *Age and sex.*
2. *Major diagnosis.*
3. *Presence or absence of diabetes mellitus.*
4. *Use of diuretics and digitalis preparations.*
5. *Clinical evidence of dehydration.*
6. *History of vomiting, diarrhea or poor oral intake of food.*
7. *Results of serum urea nitrogen and creatinine determinations and urine specific gravity.*
8. *Patient outcome (death, transfer or discharge).*

Data were tabulated to show the age distribu-

tion of the patients, their diagnoses, factors contributing to their hyponatremia, its severity and outcome.

RESULTS

The results are presented in Tables I-IV. Table I lists patients by age and sex. Table II lists their primary diagnoses. Table III lists other factors associated with the condition. Table IV correlates severity of the hyponatremia with eventual outcome of the case.

DISCUSSION

Table I shows that most of the patients were old, 60% being over 70 years of age. Less than 30% of all medical-surgical admissions were of this age group.

The major manifestations were the classical ones of weakness and orthostatic hypotension, often with reversible organic psychosis.[3]

The diseases and conditions listed in Table II are those to be expected in the elderly. Additional primary diagnoses included one case each of thrombophlebitis with pulmonary embolism, varicose ulcers, acute pancreatitis, urinary tract infection, acute cholecystitis, digitalis toxicity, benign gastric ulcer, intestinal obstruction and chronic active hepatitis. Most of the patients fall into the group of hyponatremic patients with volume depletion as defined by Herbert and Lemann.[4]

Since there were no infants or small children in the series the pediatric condition of acute hyponatremic coma with cerebral edema was not observed.[5]

Table III shows that such classical causes of hyponatremia as hypopituitarism, hypothyroidism, diabetic acidosis and renal failure are less important in the primary-secondary care institution than in larger hospitals.[6] Laboratory artifacts such as hyperglycemia[7] and hyperlipidemia[8] induced hyponatremia did not occur. Only three patients were on Chlorpropamide, a drug with antidiuretic effect.[9] In all three, major fluid losses were more important than the use of Chlorpropamide in precipitating hyponatremia. Other drugs implicated as causes of SIADH (Vincristine, Cyclophosphamide, Imipramine, Thiothixene)[10] were not used by these patients.

None of the patients had consumed large quantities of beer although some may have drunk considerable water between episodes of vomiting.

In a series reported from the Los Angeles

TABLE I

AGE AND SEX OF PATIENT

Age Range	*No. of Patients*
20 to 50 years	3
51 to 70 years	12
71 to 90 years	24
Sex	
Male	14
Female	25

TABLE II

MAJOR DIAGNOSES ASSOCIATED WITH HYPONATREMIA

Major Diagnoses	*No. of Patients*
Arteriosclerotic or hypertensive cardiovascular disease	8
Cerebrovascular accident	6
Osteoporotic fracture of femoral head	5
Carcinomatosis	4
Gastroenteritis	3
Chronic obstructive pulmonary disease	2
Alcoholism, acute	2
Diabetic acidosis	1

TABLE III

FACTORS ASSOCIATED WITH HYPONATREMIA

Factors	*No. of Patients*
Clinical evidence of dehydration	39
Diuretic use	18
History of poor oral intake	18
Weakness and/or mental confusion	16
Initial use of electrolyte-free I.V. solutions	15
Digoxin use	12
Vomiting or diarrhea	11
Post-operative state, fractured hip	5
Diabetes mellitus	6
Diabetes mellitus treated with chlorpropamide	3
Renal impairment	0

TABLE IV

SEVERITY AND OUTCOME

Number of patients	*Serum Sodium Level (mEq/L)* 100-110	111-120	121-129
Total	3	4	32
Number died	0	0	4
Number transferred	0	0	5
Number discharged stable or improved	3	4	23

County Hospital,[6] 25 of 188 patients with serum sodium below 120 mEq/L had no other explanation for it than the use of diuretics. These patients were not dehydrated and had a "dilutional" syndrome due to renal water saving. Although many patients in the present series were on diuretics, none of them had hyponatremia unless vomiting, diarrhea or anorexia was also present and all were dehydrated.

The seven patients with severe hyponatremia had causative factors different only in degree from those with mild. Their risk of death was no greater and none required transfer to a tertiary care facility. Four patients with lesser degrees of hyponatremia died from underlying disease after electrolyte balance was achieved. The severity of their illness gives some support to Flear's theory[11] that hyponatremia is in part a non-specific manifestation of "sick cells" with failure of the membrane-based ion pumps. Five patients were transferred to tertiary care after electrolyte balance was achieved. Two of them had thrombotic episodes possibly related to the precipitating episode of dehydration. Overall, the total mortality was consistent with the patient's age and severity of underlying disease. In no case could death be reasonably ascribed to hyponatremia nor could its prevention have been credited to prompt and vigorous correction of electrolyte imbalance.

Use of electrolyte-free intravenous solutions often changed a non-hyponatremic patient into a hyponatremic one. A common pattern observed among many patients, including five of the postoperative ones, was that of initial hemoconcentration with high urine specific gravity and hematocrit and relatively low serum sodium and chloride leading to therapy with two or more liters of 5% glucose in water. Hyponatremia would be documented the following day. Patients with fractured hips were particularly vulnerable to this process.

All patients were cautiously corrected with relatively small amounts of 0.9% sodium chloride solution given intravenously over a period of several days. None of them developed fluid overload during therapy and all but three of them had prompt correction of their hyponatremia, a situation ruling out the presence of SIADH.

Two patients, including one from the more severely affected group, proved resistant to full correction. They stabilized at values of 125 mEq/L despite adequate supplementation with potassium chloride. All additional intravenous sodium chloride given was promptly lost into the urine. Possibly, these patients had re-set hypothalamic "osmostats" at a new level.[12]

Only one patient had good evidence for SIADH, maintaining a concentrated urine despite administration of intravenous fluid. He responded well to fluid restriction.

All three of these patients were discharged improved but still hyponatremic.

Hyponatremia is common in elderly patients seen in rural practice. It is usually mild and responsive to cautious treatment. Vomiting, diarrhea and anorexia are major precipitating factors and diuretic use a minor one. Physicians can prevent the development of much hyponatremia by using some electrolyte-containing solution. This is preferred to the exclusive use of glucose in water in the intravenous therapy of dehydrated patients with serum sodium less than 140 mEq/L.

SUMMARY

1. Hyponatremia is common in rural practice. The typical patient is elderly and presents with weakness and/or mental confusion and is clinically dehydrated.

2. Most cases of hyponatremia are mild and easily corrected with intravenous normal saline. Occasional patients will not restore serum sodium to normally accepted levels and will waste additional I.V. sodium into the urine. True water intoxication and inappropriate secretion of ADH is rare.

3. Diabetic acidosis and renal failure are uncommon causes of hyponatremia.

4. Hyponatremia is usually caused by vomiting, diarrhea and/or anorexia associated with underlying diseases common in the age group such as heart disease, cancer, stroke or serious infections.

5. Use of diuretics contributes only in a minor way to the development of hyponatremia.

6. Some hyponatremia is iatrogenic, due to hemodilution of previously sodium-depleted dehydrated patients by the use of electrolyte-free intravenous solutions.

7. Hyponatremia, even of extreme degree, is well tolerated by patients in which it develops gradually. It does not, in itself, cause death and can safely be treated slowly in order to avoid pulmonary edema and other consequences of fluid overload.

REFERENCES

The references noted in this paper may be obtained from the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

Treatment and Survival of Breast Cancer Patients in Iowa—1969

JOHN W. BERG, M.D.
Iowa City

Analysis of all breast cancer cases seen in Iowa in 1969 showed 3 unexpected results: (1) Patients presented with earlier disease and fewer node metastases than expected. (2) Results were significantly better when the operation was a radical mastectomy than when lesser operations were chosen. (3) If node metastases were present, postoperative irradiation improved survival but probably to an important degree only if supervoltage therapy were used.

THIS INAUGURATES a series of reports on cancer in Iowa compiled from data developed by the Iowa Cancer Information Service of Dr. Joseph Buchwalter, the Third National Cancer Survey, and the current Iowa State Cancer Registry. The first two data sets overlap in 1969. For that year we have data on stage and treatment on almost all Iowa cancers and we know at least the rest existed. These cases reached their fifth anniversary in 1974 so they can be analyzed in terms of 5-year survival. For the most part our follow-up is negative: patients are presumed alive unless listed as dead by the State Office of Vital Statistics. The error due to patients dying out of state is presumed small and in any case should not affect comparisons among groups of Iowa patients.

In 1969, 1,235 women and 6 men in Iowa were diagnosed as having breast cancer. Forty-seven of the cancers were in situ and are excluded from the survival analyses. The patients were older than in most series, partly because Iowa has an older population in general, and partly because we include all patients, not just those who could travel to a teaching hospital for treatment. The average age was 62 years. Thirty-seven percent were 70 or older, and 1 of every 8 patients was 80 or older. Just over half of the patients for whom we have data came to diagnosis within a month of awareness of a breast problem. This is particularly good in view of the high average age. It is older women who generally delay the longest. Rural Iowa women 80 or older had a poor delay record: 30% of them reported delays of a year or more.

Because of the generally good delay record, Iowa patients had a high frequency of early disease. About 10% were inoperable, which is a fairly average figure. It is generally reported, however, that only 45% of patients will have negative nodes. In this series the figure was raised to 54%. Most of the time the nodes were proven to be negative pathologically. When this was the case the patients' five-year survival was 91%. One out of every 5 patients was classed as having localized disease on clinical grounds alone without axillary biopsy. Their relative 5-year survival (counting *only* cancer deaths) was down to 70%, about the rate expected with no stage information at all. Either clinical staging was terribly inaccurate in this group or, what in my personal opinion is more likely, the minority of these patients who really had axillary metastases paid a high price for the metastases being left in place.

The table gives the relative 5-year survival rates for the various kinds of treatment. The overall rate of 71% is well above the most recent national figure of 64%. Selecting the kinds of patients treated in clinical trials, the survival rate is 78% instead of 63% reported by Fisher[1] *et al* for their first clinical trial. Perhaps the big difference arises because Iowa patients totally are so different from the patients seen in teaching hospitals. The point is that not only is the overall survival different than that reported from teaching hospitals, but Iowa patients responded

Dr. Berg is director of the Iowa Cancer Epidemiology Research Center and is associated with the Iowa State Cancer Registry.

TABLE I

5-YEAR SURVIVAL RATES
CORRECTED FOR NON-CANCER RELATED CAUSES
IOWA BREAST CANCER PATIENTS 1969

Category	Number	Survival Rate %
All	1194	71
Delay		
Under 1 month	479	76
One year or more	98	59
Stage		
Pathologically negative axilla	449	91
Clinically negative axilla (no histology)	119	70
Nodes positive	419	60
One node only	71	81
Distant	72	17
Treated for Cure	1051	77
Radical Mastectomy	740	79*
Modified Radical	86	69
Simple mastectomy	192	69
Radical Mastectomy, Positive Nodes	315	64
No Radiation	170	58
Orthovoltage Radiation	55	64
Supervoltage Radiation	88	75*

* Statistically significant advantage.

differently to different treatments. Firstly, the Iowa results clearly favored radical mastectomy over other operations (see Table). With radical mastectomy there was a 5-year cancer mortality of 21%. With modified radical or simple mastectomy the cancer mortality rose to 31%.

The advantage of radical mastectomy is similar to that we observed in a previous study of a general group of patients where there was a direct and strong association between the amount of axillary tissue removed and the survival rates.[2] As noted earlier in reports from University Hospitals[3] and elsewhere,[4] there is, however, little theoretical and no practical penalty for simple mastectomies when the patients are elderly. Above 75 or 80 years of age, the operative mortality will be high with radical mastectomy. Only patients in particularly good health will have a long enough life expectancy to lose much from the slightly greater risk of recurrence accompanying a lesser operation. In the current material there were 7 postoperative deaths in 1,194 patients: one after excision of carcinoma in situ, 4 after modifed operations, 1 after a mastectomy of unknown type, and only 1, a man, among the 740 patients treated by radical mastectomy.

Besides favoring radical mastectomy, the Iowa results favored postoperative radiotherapy if nodes were positive. Overall, the survival rate rose from 58% to 71%. As the table shows, however, this came about mostly because of a 75% survival rate after supervoltage irradiation; there was much less advantage seen with orthovoltage. This may explain why other studies using orthovoltage showed so little.

The Registry did not collect information on the type of treatment given in 1970 or 1971 and did not cover the state in 1972. Hence, it will be some time before data will accumulate on the newer types of modified operations that seem to have come into fashion. Moreover, it probably is not worthwhile trying to study more recent results unless we can re-establish the general cooperation in gathering detailed information about staging, treatment, and especially follow-up that briefly flourished in Iowa in 1969 and 1970. If provocative results, such as those presented here, do reawaken interest in local cancer clinics, cancer programs and cancer registries, we at the State Registry will be more than happy to assist in any way we can.

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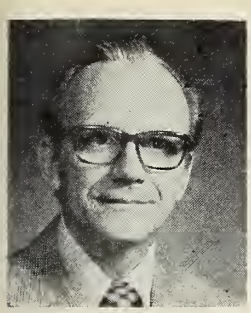

Editorials

M. E. ALBERTS, M.D., Scientific Editor

BICENTENNIAL—1776/1976

Two hundred years may seem a long time. Our great United States, however, is young when compared to other unions of people which formed themselves into specific nations. Members of the medical profession have held prominent positions in the evolution of most societies. So it is when we look back upon the 200 years of United States history.

Four practicing physicians were among the signers of the Declaration of Independence, and each of them remained active in political life, in addition to practicing medicine. Doctor Matthew Thornton of New Hampshire later became an associate justice of the Superior Court and a member of the state senate. Another signer, Doctor Josiah Bartlett, also from New Hampshire, became a jurist in the Supreme Court, as well as the first president of the New Hampshire Medical Society. Doctor Lyman Hall, who represented Georgia as a signer, later became the state's governor. The best known physician to sign the Declaration of Independence was Doctor Benjamin Rush of Pennsylvania. Well trained, with advanced medical education in Edinburgh, Scotland, Rush was very active in political and medical endeavors. Another signer, Doctor Oliver Walcott of Litchfield, Connecticut, never practiced medicine after his professional training, choosing instead to be a politician.

As the United States struggled forward, there were many significant medical events which included:

- *Harvard Medical School was founded in 1782.*
- *Benjamin Franklin invented bifocal spectacles in 1784.*
- *Hezekiah Beardsley of Connecticut first described congenital hypertrophic pyloric stenosis in 1788.*
- *In 1800 Benjamin Waterhouse introduced vaccination in America.*

Before 1800, medical societies had been formed in New Jersey, Massachusetts, Philadelphia, Delaware, Maryland, South Carolina and New Hampshire. Our Iowa Medical Society is relatively young, dating from 1850. At that time our United States was 75 years old, and the California gold rush was stirring the hearts of adventurous men. However, in another 10 to 12 years, brother was killing brother in the Civil War. The loss by death of more than 600,000 healthy young men was an unforgettable tragedy for the struggling nation. Medical care of the soldiers was hampered by political conflicts, yet the physicians of the Union Army were courageous, suffering higher casualties than any other staff corps of the army. In many instances they were beset by bad management which hampered the acquisition and transportation of medical supplies and personnel. The Confederate Army likewise sustained needless death and suffering from poor management. Both the North and South were unprepared to care for wounded soldiers. A much improved military medical organization began to take shape after the war. A public health movement was also begun.

The War Between the States was over by 1865, and during the last half of the nineteenth century great names in medicine appeared. European medicine continued its domination but America was coming of age.

- *Charles McBurney published his classic paper on appendicitis in 1889.*
- *Silas Wier Mitchell became an outstanding neurologist.*
- *William Osler was appointed professor at Johns Hopkins University.*
- *George Huntington described chorea.*
- *Austin Flint wrote of cardiac murmurs.*

• *William S. Halstead pioneered in surgical technique at Johns Hopkins.*

These men joined with M. Claude Bernard, Louis Pasteur, Robert Koch, Joseph Lister, and Marie and Pierre Curie. How exciting it must have been to be introduced to so many new and wonderful medical discoveries. Yet, how frustrating it must have been to helplessly care for patients stricken by the unrelenting scourges of smallpox, diphtheria and tuberculosis, as well as pertussis, pneumonia and scarlet fever. American physicians sought further knowledge and many studied in Paris and Vienna and Berlin; today, physicians come to the United States for advanced medical training.

TWENTIETH CENTURY MEDICINE

The twentieth century has witnessed American medicine progressing steadily and rapidly. The advances have been a reflection of the progress of civilization and culture in the Western hemisphere. The 1920's introduced insulin for the treatment of diabetes mellitus, and the use of liver extract for pernicious anemia. In spite of the Great Crash of 1929, and the politics of the New Deal in the 1930's, medicine made striking advances in surgery, chemotherapy and biologicals. Landsteiner received the Nobel Prize in 1930 for his discovery of human blood groups.

The Iowa State Medical Society, as it was earlier known, was concerned with the part that medicine contributed to society in the early 1930's. A Committee on Child Health and Protection was developed. The purpose of that committee was educational, with studies pertaining to complications of pregnancy, nutrition of pregnancy, infant feeding, pre-school examinations, immunization and school health programs. At the annual banquet in 1935 the physicians heard a talk entitled, "Are Doctors Human?" Even then, physicians were concerned about their image.

BOUNTIFUL YEARS

The late 30's and early 40's brought World War II and penicillin. From there on the significant contributions from year to year are so numerous one becomes lost in the maze of assessing relative significance. The late 40's provided my introduction to medicine, and it is phenomenal the advances that have been made since my graduation from medical college—antibiotics of many kinds, corticosteroids, vaccines for poliomyelitis, measles, rubella and other diseases, cardiac surgery, organ transplantation, laser techniques, computerized laboratory procedures, radioactive assays and many more. What can the future hold after such a flurry of advancement?

FUTURE PREDICTIONS

If I may be so bold as to project into the future, I would like to predict some advances we may witness. Some of these may be already on the drawing board or in experimental phases. Surgeons will be much more able to correct congenital malformations as well as post-trauma deformities. Other physical modalities will join ultrasound, light and laser in the treatment of disease. New vaccines will be developed. Computers will enter more and more into the practice of medicine with physicians' offices tied in with hospital and third party data processing. I fear that patients will become numbers rather than personal entities because of our computer age. The computer readout will give a series of numbers: patient number, diagnosis number, treatment number, physician number, follow-up number, and on and on. (I hope we do not have to include a lawyer's number in the long list.)

Will we be socialized any more than we are now? Perhaps to some extent at both extremes of patient age—infants and children as well as the aged. We will see more government intervention, but I feel the bureaucrats will eventually see that total socialized medicine would constitute fiscal suicide.

There must be a continuation of personal initiative to care for some of the problems of life—health, along with food, lodging, etc. True, there will be third party payments of medical fees with the attendant paperwork, but most of that will be on computers, so perhaps there actually will be less paper involvement.

It has been a rough and tough 200 years. In some ways the next 200 years may be rough also, but in different ways. It is mind-boggling to consider what can happen. Can the human brain absorb all the new knowledge added to the advances of the past? Will every physician have to be a super-specialist in order to be competent? It would seem the jack-of-all-trades concept cannot continue because of the complexities of the many concepts of patient care. Continuing education and re-assesment will be needed.

Let us look back for encouragement and ahead with anticipation!—M.E.A.

Educationally Speaking

by RICHARD M. CAPLAN, M.D.

"HAPPINESS IS . . . SIMPLY GROWTH"

The opening, "Happiness is . . ." has been made famous in recent years by Charles Schulz' cartoon characters. But from the remotest of recorded history, man has struggled to complete the sentence. A recent version is from the Irish author William Butler Yeats. His dictum: "Happiness is neither virtue nor pleasure nor this thing nor that but simply growth. We are happy when we are growing."

I wonder if very many physicians think of their activity as promoting their personal *growth* when they partake of continuing education. Does reading even a single journal article produce some growth? I think yes, even though our measuring instruments are usually too crude to discern it. Apply the growth metaphor to a garden. No one would protest the notion that regular applications of water and fertilizer will augment growth and promote the desired product. At the same time, control of weeds and proper pruning is likewise important activity. Similarly, clinicians need to read regularly and use other methods to replenish their intellectual soil, while simultaneously culling from their armamentarium of skills and understanding those behaviors that time shows to be inappropriate and to merit abandonment.

Now that the garden season is here and you're cheerfully in the throes of yard and garden work again, let your mind flicker, as you dig or rake, to the potential for personal growth that lies dormant in your own continuing effort and study. If Yeats is right, and if you assure that you keep up the effort to grow, it's nice to know that growth will bring happiness.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

IMPORTANT HOUSE CALL

Iowa anesthesiologists converged on Des Moines May 19 to lay before the state's lawmakers medicine's current liability insurance plight. Between 60 and 70 physicians, including several from other specialties, participated in the one-day effort to focus public and legislative attention on the deteriorating medical malpractice insurance situation. Strong emphasis was placed on the unavailability of the excess or umbrella coverage for anesthesiologists.

The event was organized and planned by the Iowa Society of Anesthesiologists. It included a morning briefing, a press conference and lunch at the Iowa Medical Society Headquarters with an afternoon visit to the Statehouse. Conversations were principally with members of the Iowa House of Representatives. The physicians urged House passage of Senate File 1310 with incorporation of the Small amendment.

Elective surgery in many Iowa communities was curtailed for the day while the anesthesiologists were in Des Moines. Provision was made for emergency service. Charles N. Hull, M.D., Des Moines, and Donald L. Sweem, M.D., Des Moines, as president and president-elect of the Iowa Society of Anesthesiologists, coordinated the May 19 project.

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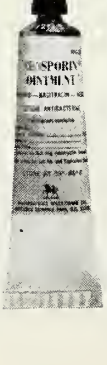
Complete literature available on request from Professional Services Dept. PML.



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State Department of Health

TRICHINOSIS OUTBREAK IN POSTVILLE

On December 29, 1975, a physician in Postville, Iowa, reported to the Iowa State Department of Health that during the week he observed three patients with muscle aches, facial swelling and periorbital edema, and that he suspected trichinosis. All three patients had consumed locally produced venison and pork summer sausage on and after November 30, 1975. Also on December 29, 1975, a physician in Waterloo, Iowa, reported clinical trichinosis in a husband and wife living in Waterloo, who on December 6, 1975, had eaten venison and pork sausage provided by a relative from Postville. Later, studies confirmed the presence of viable *Trichinella spiralis* larvae in the venison sausage.

The implicated sausage was produced by a custom locker plant in a 550 lb batch, using venison from 13 deer shot by hunters during the 1975 hunting season, mixed in a 2:1 proportion with pork. The pork came from Boston Butt cuts procured via an area grocer from a regional warehouse in LaCrosse, Wisconsin. The warehouse obtained the pork from one or both of two abattoirs in Minnesota operated by nationally-based packing companies under USDA inspection.

The sausage had been prepared for and distributed to the contributing deer hunters, and secondarily given to their families, local friends, and a host of casual Christmas holiday visitors from other communities in Iowa, other states, and one province of Canada. At least 242 persons were identified as having eaten from the sausage, of whom 73 have had clinical symptoms compatible with trichinosis. Paired sera from 4 of these persons have either converted from non-reactive to reactive or demonstrated a 4-fold increase in titer to *T. spiralis* antigen by Bentonite Flocculation Test (BFT) performed by the Iowa State Hygienic Laboratory. Single, acute phase serum samples were examined from an additional 61 of the ill people, and 13 (21%) have been found reactive by BFT. A single gastrocnemius muscle biopsy performed on one typically ill patient showed signs of inflammation, but no *T. spiralis* larvae were found.

Exposure to the sausage associated with illness occurred primarily through its distribution within two extended-family groups and through a barbecue party on November 30, 1975, at which hunters and friends celebrated the successful hunting season. Evidence of *T. spiralis* infection was found within the two extended-family groups, and of 28 persons eating one or more slices of the implicated sausage at the barbecue, 26 (AR 93%) developed clinical trichinosis between December 9, 1975, and January 5, 1976.

The 550 lb batch of sausage was prepared by grinding the venison and pork, adding the seasoning, and stuffing the mixture into artificial casings, 2½″ in diameter, to form "sticks" or "links" approximately 18″ in length. The sticks were then smoked for 2½ days, with burning sawdust and wood chips used for both heat and smoke. According to the locker plant operator, a single thermometer implanted in one stick of sausage registered a temperature of 155° F (68.3° C) during the processing.

At the Veterinary Medical Research Institute Laboratory, Iowa State University, 100-gram samples of the implicated sausage were examined by the Baermann digestion method, and 23 (51%) of 45 samples were determined to be positive for *T. spiralis* larvae. Counts of dead larvae ranged from 1-16 per 100 grams; 1-65 viable larvae were found in 20 (87%) of the positive samples. Protein coagulation testing performed on 3 samples by the Food Laboratory, Iowa Department of

Trichinosis Outbreak in Postville

(Continued from page 225)

Agriculture, indicated that during processing the interior of the sausage had reached temperatures of only 124° F, 125° F and 122° F, respectively. On visual inspection, sticks of the sausage appeared soft and "raw" in the center.

Two additional batches of venison/pork sausage were made by the same sausage maker in the same manner for other hunters but no illness has been recognized in at least 40 persons identified as having eaten only from these batches. Baermann digestion examination of samples from these two batches failed to reveal any *T. spiralis* larvae. Pork used in these two batches was from both federally-inspected and locally-slaughtered swine, coming from entirely different lots than pork used in the implicated batch.

Persons possessing the implicated sausage were advised to either destroy remaining sausage or cook it thoroughly prior to consumption. Since viable larvae were detected in samples that had been stored in a home freezer for over 30 days, such freezing was not recommended as a technique for disinfection of the sausage. Persons not yet ill but known to be exposed to the implicated sausage within the preceding 20 days were referred to local physicians for consideration of prophylactic thibendazole therapy.

Reported by:

M. F. Kiesau, M.D., Practicing Physician, Postville, Iowa;
R. H. Palmer, M.D., Practicing Physician, Postville, Iowa;
R. R. Roth, M.D., Practicing Physician, Waterloo, Iowa;
A. F. Wiley, M.D., Chairman, Allamakee County Board of Health, Waukon, Iowa;
W. F. Zimmerman, Ph.D., Parasitology Section, Veterinary Medical Research Institute, Iowa State University, Ames, Iowa;
W. J. Hausler, Jr., Ph.D., Director, Iowa State Hygienic Laboratory, Iowa City, Iowa;
C. H. Creamer, D.V.M., Food Laboratory, Iowa Department of Agriculture, Des Moines, Iowa.

Morbidity Report for April, 1976

Disease	Apr. 1976	1976 to Date	1975 to Date	Most April Cases Reported From These Counties
Adenovirus	2	8	3	Montgomery, Sac
Amebiasis	4	17	—	Boone
Ascariasis	5	11	6	Hamilton
Chickenpox	1649	7557	1538	Dubuque, Linn, Polk, Scott
Conjunctivitis	271	1009	591	Black Hawk, Bremer, Harrison
Erythema infectiosum	18	81	97	Howard, Marion
Gastrointestinal viral inf.	1473	14672	12985	Floyd, Linn, Sioux
Giardiasis	2	13	4	Dubuque, Hamilton
Hepatitis				
A (Infectious)	2	45	66	Linn, Pottawattamie
B (Serum)	4	25	31	Boone, Emmet, Linn
type unspecified	1	8	11	Black Hawk
Histoplasmosis	2	8	12	Polk
Impetigo	52	375	258	Scattered
Infectious mononucleosis	114	610	597	Johnson, Linn, Polk
Influenza, lab confirmed	32	143	171	Jackson, Johnson, Linn, Polk
Influenza-like illness	5038	37209	34446	Linn, Mills, Polk, Story
Meningitis type unspecified	2	2	18	Clayton, Polk
Meningococcal meningitis	1	9	6	Hancock
Mumps	214	911	592	Harrison, Jackson, Polk
Pediculosis	40	206	149	Scattered
Pneumonia	141	609	513	Harrison, Polk, Scott
Rabies in animals	13	35	29	Carroll, O'Brien
Rheumatic fever	1	14	7	Muscatine
Ringworm, body	28	140	126	Scattered
Rubella	1	12	8	Polk
Salmonellosis	27	33	54	Scattered
Scabies	52	301	188	Polk, Scott
Shigellosis	4	11	26	Scattered
Streptococcal infections	1437	8704	4912	Jackson, Johnson, Polk
Tuberculosis				
Total ill	9	39	39	Scattered
Bact. positive	8	35	18	Scattered
Venereal diseases				
Gonorrhea	436	2135	2017	Black Hawk, Linn, Polk, Scott
Syphilis	28	123	101	Black Hawk, Mahaska, Polk

Laboratory Virus Diagnosis Without Specified Clinical Syndrome
Cytomegalovirus 2, Eaton's agent infection 1, Herpes simplex 10

Medical Assistants

by TENORA MEYER, CMA

PRESIDENT'S MESSAGE

I really love positive! Ever since I was a little tot working on one project or another, I'd get to a point where I thought any further step was an impossibility and start to abandon ship. My mother would pause to say, "Well, you know can't never did anything," which put the challenge back in my eye. She so successfully programmed my brain cell center I felt I could tackle anything. Later, when I was married, my husband and I learned together: cooperation plus determination equals success. Positive is what the State of Iowa wants to be. Let's take a look at AAMA State of Iowa's past and talk about our future goals.

Leanna Rist

MEMBERSHIP: National has challenged us to achieve an increase of 72 members in 1976. We have already had increases of 73 members, which is really something to be proud of. I am proud of the hard work, determination and cooperation you have put forth, but I must challenge you to add some finishing touches with an additional goal of 26 members. We want to help National make the anniversary goal of 1976.

EDUCATION: The last five or six years most of our chapters have made strides in their educational programs. The Board of Trustees has voted to implement a formal program of continuing education with proof of participation necessary to retain certification. The seminars offered will therefore serve a threefold purpose. They will (1) offer CEU units to all in their area to retain their certification, (2) offer educational opportunities to those studying for their CMA, and (3) attract new members interested in educational opportunities. The purpose of our organization is education—to improve our abilities, to increase our professionalism and our productivity.

So medical assistants of Iowa, my wish for you is to always thirst for the knowledge you can at-

(Please turn to page 231)

CONCLUDING COMMENTS

With this issue I turn my reporting duties to Betty Ehlert, CMA-A, of Des Moines. It has been a privilege to serve five years as Medical Assistant reporter for the JOURNAL. I hope my efforts have been of some interest and benefit. Writing for an educational journal, such as this, is a learning experience. Unless the articles are all truly creative, one must explore to obtain material and thus gain knowledge. As a representative of our State Society of Medical Assistants, I want to express our thanks for the space provided in the JOURNAL and for the support of the Medical Society. We hope through our organization we can provide medical assistants in-service training through publications, local meetings, seminars, state and national conventions. The fact that we are growing each year in numbers and in the expansion of our certification program speaks well for the efforts of the members and the judicious use of the grants provided by the AMA and others.

My thanks to Mr. Neumann for his fine editing and assistance. I know my successor will reap as much benefit as I have in these past five years.—*Tenora Meyer, CMA*

About IOWA Physicians

Dr. Richard M. Caplan, associate dean of continuing medical education at U. of I., **Dr. Russell Noyes, Jr.,** associate professor in department of psychiatry, participated in recent seminar on terminal illness in Iowa City. . . . **Dr. Stuart Sybesma** will begin a surgical practice in Luverne in July. Dr. Sybesma earned the M.D. degree at U. of I. College of Medicine, where he received the Ewen McEwen Award for highest scholastic achievement in four years of medical school. Dr. Sybesma interned at Los Angeles County Harbor General Hospital; practiced family medicine in California from 1969 to 1971, then practiced in Newton, Iowa, for two years before returning to California for a surgical residency at Kern County General Hospital in Bakersfield. . . . **Dr. Richard T. Satterfield,** Sioux City, was elected secretary of the Iowa Psychiatric Society at recent annual meeting in Des Moines. . . . **Dr. T. J. Michelfelder,** Fort Dodge dermatologist, was guest speaker at April meeting of the Wright County Medical Society. Dr. Michelfelder described the more common dermatoses and the latest treatments. . . . **Dr. Martin Sands,** associate in department of dermatology at U. of I. College of Medicine, has entered private practice in Iowa City. Dr. Sands is a 1971 medical graduate of the U. of I. and served a residency in dermatology there. . . . New officers of Iowa Radiological Society are—**Dr. Robert Guthrie,** Waterloo, president; **Dr. Robert Brown,** Iowa City, president-elect; **Dr. Dale L. Roberson,** Cedar Rapids, secretary-treasurer; and **Dr. Ben Broghammer,** Mason City, and **Dr. John Lohnes,** Cedar Rapids, councilors.

Dr. A. C. Wubbena, Rock Rapids physician for almost 40 years, was recently honored at a reception given by the Rock Rapids community. Dr. Wubbena received the M.D. degree at Rush Medical College in Chicago and interned at Chicago's Presbyterian Hospital. For a number of years, he owned and operated a private hospital in the community and later donated the equipment to Merrill Pioneer Community Hospital when that facility was opened in 1958. . . . **Dr. Paul M. Seebohm,** executive associate dean of U. of I. College of Medicine, was presented the Distinguished Internist Award of the American Society of Internal Medicine at recent meeting of Iowa Clinical Society of Internal Medicine in Iowa City. . . . **Dr. George Winokur,** head of the U. of I. Department of Psychiatry, spoke recently on "Clinical Aspects of Depression and Mania" at Coe College in Cedar Rapids. Dr. Winokur's speech was sponsored by the Mental Health Association of Linn County and the Linn County Psychiatric Clinic. . . . **Dr. Jose Kua,** Miami, Florida, will begin family practice in Avoca in July. A native of the Philippines, Dr. Kua received his medical education in Manila. He is currently completing his medical training and finishing his residency in surgery at Mount Sinai Medical Center in Miami, Florida. . . . **Dr. William W. Ireland,** Ottumwa, was recently appointed city board of health physician. . . . **Dr. Robert Heise** will join the Osage Medical Group July 1 in family practice. Dr. Heise received the M.D. degree at University of Nebraska Medical School and completed his family practice residency at U. of I. College of Medicine.

Dr. Robert E. Smith, Iowa City, has been appointed assistant director in clinical research department of Parke, Davis, & Co. in Ann Arbor, Michigan. . . . **Dr. Charles Read,** president of Iowa Diabetes Association and professor in department of pediatrics at U. of I. College of Medicine, was guest speaker at recent meeting of Henry County Diabetes Association. . . . **Dr. Douglas A. Bright** will join **Dr. K. A. Garber** in family practice in Corydon in July. Dr. Bright received the M.D. degree at U. of I. College of Medicine and completed his family practice resi-

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dency at Hennepin County General Hospital at University of Minnesota in Minneapolis. . . . **Dr. Henry M. Perry,** Bloomfield, was guest speaker at recent Mt. Pleasant meeting sponsored by Henry County Veterans of Foreign Wars Auxiliary. Dr. Perry spoke on "Cancer of the Rectum and Colon." . . . **Dr. Paul Tice** has joined **Drs. John Baker** and **John Houlahan** in Mason City. Dr. Tice received the M.D. degree at University of California, San Diego, and completed his postgraduate training at Providence Hospital in Seattle, Washington. He is a third-generation Iowa physician. His grandfather, **Dr. C. B. Tice,** established a medical practice in Mason City in 1928, and his father, **Dr. George Tice,** is associated with the Independent Medical Surgical Group in Mason City.

Dr. Daniel J. Cole, Fort Dodge, was guest speaker at St. Edmond's High School commencement exercises. Dr. Cole is an alumnus of St. Edmond's. . . . **Dr. David Ramsey** has joined the staff at the Fairfield Clinic in family practice. A graduate of University of Texas Medical School, Dr. Ramsey recently completed a family practice residency at U. of I. College of Medicine. . . . **Dr. Chote Thumasathit** and his wife, **Dr. Bhoonsri Thumasathit,** Hull physicians, are recipients of a plaque recently presented by Hull City Council in appreciation of their assistance in Hull emergency medical services program. . . . **Dr. Jon R. Leach** will begin a surgical practice in Clarinda in August. Dr. Leach received the M.D. degree at University of Missouri School of Medicine and interned at Kansas City General Hospital. He is presently completing his surgical residency at Menorah Medical Center in Kansas City, Missouri. . . . **Dr. Janis Straumanis,** Solon, retired May 1, following 22 years of medical practice in Solon. A refugee from Latvia, Dr. Straumanis and his family came to the United States in 1950. Prior to locating in Solon, he was on the staff at the Glenwood State School.

Dr. Harold L. Brenton, Clear Lake, has been re-elected president and chief of the medical staff of North Iowa Medical Center. Also re-elected were: **Dr. Ki T. Song,** Mason City, vice president, and **Dr. R. Bruce Dunker,** Mason City, secretary. . . . **Dr. Charles M. Marriott,** Sioux City, was recently elected secretary of Iowa Thoracic Society.

★

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DEATHS

Dr. William M. Hale, 78, former U. of I. College of Medicine faculty member, died March 26 at his home in Mountain View, Arkansas. From 1938 to 1949, Dr. Hale was professor and head of the department of microbiology at U. of I. College of Medicine. Dr. Hale was the first to organize the department as a separate discipline. He received the M.D. degree at Yale University School of Medicine. Prior to retirement in 1964, Dr. Hale was professor of microbiology at University of Tennessee College of Medicine in Memphis.

Dr. Charles W. Latchem, 62, Des Moines, died May 6 at Iowa Methodist Medical Center. Dr. Latchem received the M.D. degree at Duke University Medical School and served his residency in urology at the Mayo Clinic in Rochester, Minnesota. Dr. Latchem was a member of American College of Surgeons and American Urological Society.

MEDICAL ASSISTANTS

(Continued from page 227)

tain in our meetings, classes, seminars, and conventions. When you find a piece of knowledge you've forgotten, cram it back into a remembering position. Treat your mind with tender loving care and *use* it. The Iowa percentage of certified medical assistants has been good. Let's keep it high and inspire our young members to reach this goal.

I challenge each of you in 1976 to have a positive attitude, not only toward your organization, but toward yourself. Think positive about your patients—love them all; cranky ones, sad ones, talkative ones, forgetful ones, nervous ones —all of them, treat them with love and respect. The considerate care of your doctor's patients is the best gift you can give him. Don't forget to appreciate your bosses; they make it all happen.

I've challenged you to a number of goals this year. And I challenge my chairmen, officers, and myself, Leanna Rist, as president, to serve you the very best we can. We're going to all remember that *"can't"* never did anything, and that cooperation plus determination equals success. Together we will accomplish an increase in membership and a furtherance of our educational opportunities.—*Leanna Rist, CMA-A,* President

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OB-GYN—Certified or Board Eligible, to join pro-life specialist in medium sized clinic. Call presently shared by three-doctor arrangement. Fine N.E. Wisconsin city of 100,000. Excellent facilities. Starting salary and fringe benefits over $50,000. Early partnership. Availablility—immediate through July, 1977. Write No. 1514, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

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LE MARS, IOWA, NEEDS 3 FAMILY PHYSICIANS now to provide medical service to a county-seat community of 8,500 and a medical area of 25,000. Three doctors now practicing need immediate help because of the retirement of colleagues. You have your choice of joining existing clinics or establishing your own practice, fully supported by present physicians. New 44-bed municipal hospital entirely paid for by local funds will open this spring. Excellent public and parochial school systems, 4-year accredited liberal arts college, rich agricultural area, variety of diversified clean industries, modern progressive business district and excellent recreational facilities are available for your enjoyment and relaxation. Le Mars is centrally located in northwestern Iowa within easy driving distance to the metropolitan areas of Sioux City, Omaha, Des Moines, Minneapolis and Sioux Falls. If you are looking for quality of life in a wholesome environment, we think you will be interested in Le Mars. For further information contact: Floyd Valley Medical Manpower, 115 Plymouth St. NW, Le Mars, Iowa 51031, phone 712/546-5306.

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respond to one

According to her major
ptoms, she is a psychoneu-
patient with severe
iety. But according to the
ription she gives of her
ngs, part of the problem
sound like depression.
is because her problem,
ough primarily one of ex-
ve anxiety, is often accom-
ed by depressive symptom-
gy. Valium (diazepam)
provide relief for both—as
xcessive anxiety is re-
d, the depressive symp-
associated with it are also
relieved.

There are other advan-
s in using Valium for the
agement of psychoneu-
anxiety with secondary
essive symptoms: the
hotherapeutic effect of
um is pronounced and
d. This means that im-
vement is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

eillance because of their predisposi-
o habituation and dependence. In
nancy, lactation or women of child-
ing age, weigh potential benefit
nst possible hazard.

autions: If combined with other psy-
ropics or anticonvulsants, consider
fully pharmacology of agents em-
ed; drugs such as phenothiazines,
otics, barbiturates, MAO inhibitors
other antidepressants may potentiate
ction. Usual precautions indicated in
nts severely depressed, or with latent
ession, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

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President's Page

In early May, after I was launched as your current president, I wiped the champagne from my brow and offered some comments to the House of Delegates. Among them I included the observation that very few of our patients could pay from their own resources the charges paid in their behalf by insurance companies. The continual flow of these golden eggs is in real jeopardy. General Motors has stated that, in 1975, it spent more with Blue Cross-Blue Shield for health care of its employees than with U. S. Steel, the major supplier of metal for its cars.

There are increasing demands in Congressional hearings for some kind of control over the open-ended burgeoning costs of health care. These costs are outstripping the Gross National Product, the cost of defense, the cost of education, and the rate of inflation. Management, labor, government, and insurance companies, including the Blues, are deeply concerned and are launching examinations of the problem. These deliberations must, of necessity, include this medical society. This word of caution is a plea for restraint on our parts and a real effort to seek a solution. We will be back to this subject again.

James F. Bishop, M.D.

James F. Bishop, M.D., President

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REAFFIRM PHYSICIAN ADVERTISING PRINCIPLES

SHOULD THOSE *individuals who provide professional services to the public be able to advertise their abilities, their prices, etc.?*

Under proper circumstances. So say the *Principles of Medical Ethics* of the American Medical Association, to which most physicians subscribe.

Interestingly, the subject of professional advertising has been under recent scrutiny from several quarters. For example, the Federal Trade Commission has filed a complaint against several medical organizations, including the AMA, complaining the *Principles* restrict advertising of physicians.

Stimulated by this activity, the AMA Judicial Council has reaffirmed a long-standing policy on advertising and solicitation. It points out the *Principles of Medical Ethics* are meant to discourage abusive practices that exploit patients and the public and interfere with freedom in making an informed choice of physicians and free competition among physicians. Following is the statement of the AMA Judicial Council:

Advertising—The *Principles* do not proscribe advertising; they proscribe the solicitation of patients. Advertising means the action of making information or intention known to the public. The public is entitled to know the names of physicians, the type of their practices, the location of their offices, their office hours, and other useful information that will enable people to make a more informed choice of physician.

The physician may furnish this information through the accepted local media of advertising or communication, which are open to all physicians on like conditions. Office signs, professional cards, dignified announcements, telephone directory listings, and reputable directories are examples of acceptable media for making information available to the public.

A physician may give biographical and other relevant data for listing in a reputable directory. A directory is not reputable if its contents are false, misleading, or deceptive or if it is promoted through fraud or misrepresentation. If the physician, at his option, chooses to supply fee information, the published data may include his charge for a standard office visit or his fee or range of fees for specific types of services, provided disclosure is made of the variable and other pertinent factors affecting the amount of the fee specified. The published data may include other relevant facts about the physician, but false, misleading, or deceptive statements or claims should be avoided.

Local, state, or specialty medical associations, as autonomous organizations, may have ethical restrictions on advertising, solicitation of patients, or other professional conduct of physicians that exceed the *Principles of Medical Ethics*. Furthermore, specific legal restrictions on advertising or solicitation of patients exist in the medical licensure laws of at least 34 states. Other states provide regulation through statutory authority to impose penalties for unprofessional conduct.

Solicitation—The term "solicitation" in the *Principles* means the attempt to obtain patients by persuasion or influence, using statements or claims that (1) contain testimonials, (2) are intended or likely to create inflated or unjustified expectations of favorable results, (3) are self-laudatory and imply that the physician has skills superior to other physicians in his specialty of practice, or (4) contain incorrect or incomplete facts, or representations or implications that are likely to cause the average person to misunderstand or be deceived.

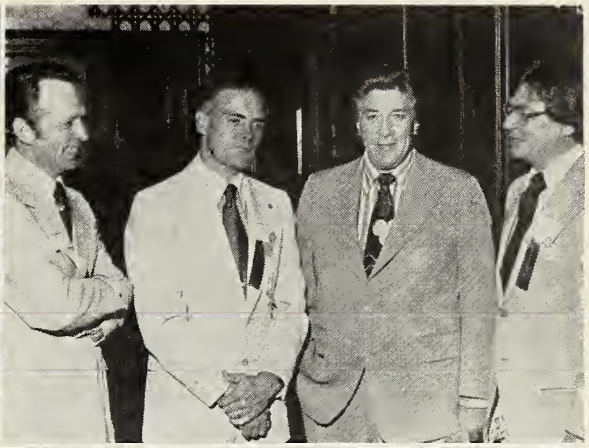
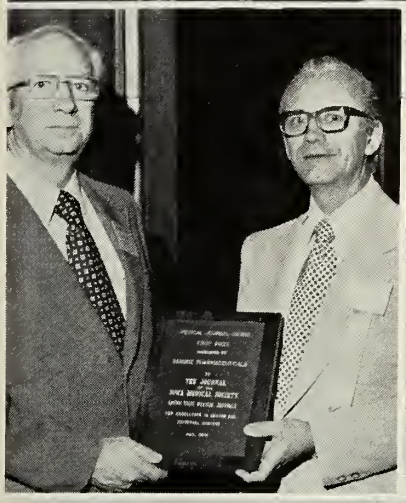
Competition—Some competitive practices accepted in ordinary commercial and industrial enterprises—where profit-making is the primary objective—are inappropriate among physicians. Commercial enterprises, for example, are free to solicit business by paying commissions. They have no duty to lower prices to the poor. Commercial enterprises are generally free to engage in advertising "puffery," to be boldly self-laudatory in making claims of superiority, and to emphasize favorable features without disclosing unfavorable information.

Physicians, by contrast, have an ethical duty

(Please turn to page 249)

IN THE PUBLIC INTEREST

1976 House of Delegates in Annual Session

LEFT PAGE—Upper: (Left) Mrs. Joyce Montag, Creston, receives the John F. Sanford Award from President Schlaser. (Center) AMA Trustee Frank Jirka, left, chats with IMS Delegate G. C. McGinnis, Ft. Madison. (Right) Bernie Saggau accepts Washington Freeman Peck Award on behalf of the Iowa High School Athletic Association. Upper Middle: (Left) D. C. Young, IMS Legislative Chairman, addresses the House. (Center) C. H. Denser, Jr., IMS Medico-Legal Chairman reports to the House. (Right) New IMS Life Members, from left, H. W. Rathe, Waverly, D. O. Bovenmyer, Ottumwa, J. M. Krigsten, Sioux City, and O. N. Glesne, Ft. Dodge. Lower Middle: (Left) J. F. Bishop, left, Davenport, accepts president's gavel from V. L. Schlaser. (Right) Elected to new IMS offices were R. D. Whinery, left, Iowa City, AMA alternate delegate, and J. H. Lohnes, Cedar Rapids, House vice-speaker. Lower: (Left) President Schlaser presents R. L. Wicks, Boone, with a past-president's plaque. Chairmen of 1976 reference committees were J. H. Coddington, Humboldt, G. E. Michel, Cherokee, and E. B. Grossman, Jr., Orange City. RIGHT PAGE—(Left) IMS Board Chairman A. J. Havlik, left, Tama, presents AMA check to J. W. Eckstein, Dean of the College of Medicine. (Center) Foundation President K. E. Lister, Ottumwa, addresses the House. (Right) From left, Eldon Huston, IMS executive vice-president; R. D. Whinery, Iowa City, U. S. Senator Dick Clark, and D. C. Young, Des Moines. Middle: (Left) Sandoz regional vice-president Edwin Haas, left, presents award to the IMS Journal Scientific Editor M. E. Alberts, Des Moines. (Center) Auxiliary President Erlene Veverka, Prairie City, speaks to the delegates. (Right) AMA delegates J. H. Rhodes, Pocahontas; Erling Larson, Davenport, and J. R. Anderson, Boone. Lower: IMS Judicial Council: Seated: D. J. Walter, Des Moines; D. M. Youngblade, Sioux City, and J. E. Tyrrell, Manchester. Standing: S. A. Smith, Oskaloosa; D. F. Rodawig, Jr., Spirit Lake; E. E. Linder, Ogden; W. V. Wulfekuhler, Mason City; R. L. Kent, Fort Madison; C. L. Kelly, Jr., Charles City; C. H. Denser, Jr., Des Moines, and A. L. Sciortino, Council Bluffs. (Right) IMS Board of Trustees, seated, from left, A. J. Havlik, Tama, chairman; J. F. Bishop, Davenport, president; and L. W. Swanson, Mason City, president-elect. Standing, J. H. Kelley, Des Moines, trustee; A. W. Boone, Davenport, vice-president; Hormoz Rassekh, Council Bluffs, trustee, and W. R. Bliss, Ames, secretary. Not pictured is T. A. Burcham, Des Moines, treasurer.

alone together...

. . . with your financial problems! You could have left the phone and stock quotations with the Trust Department of your Iowa bank and spent your day off really relaxing with your hobby or family. It frequently happens, though, that as a busy professional person you must use your spare time to study, investigate and analyze the facts about investments when you are trying to manage the job yourself. An Iowa Trust Department could give you back your spare time if you were to turn the task over to them. Studying, investigating and analyzing investments of all kinds is their business. They have a continual flow of accurate investment data on which to base sound decisions . . . tailored to the professional person's financial needs. With a Living Trust or Investment Management Account all the details of a wise investment program are handled for you by our skilled and experienced professionals. We can give you the time to face more important free time decisions: a spinner or a jig...a five or seven iron...dinner and dancing or a movie...softball or football with the kids...And our fee is deductible, so you see Iowa Trust Departments can save you time *and* money.

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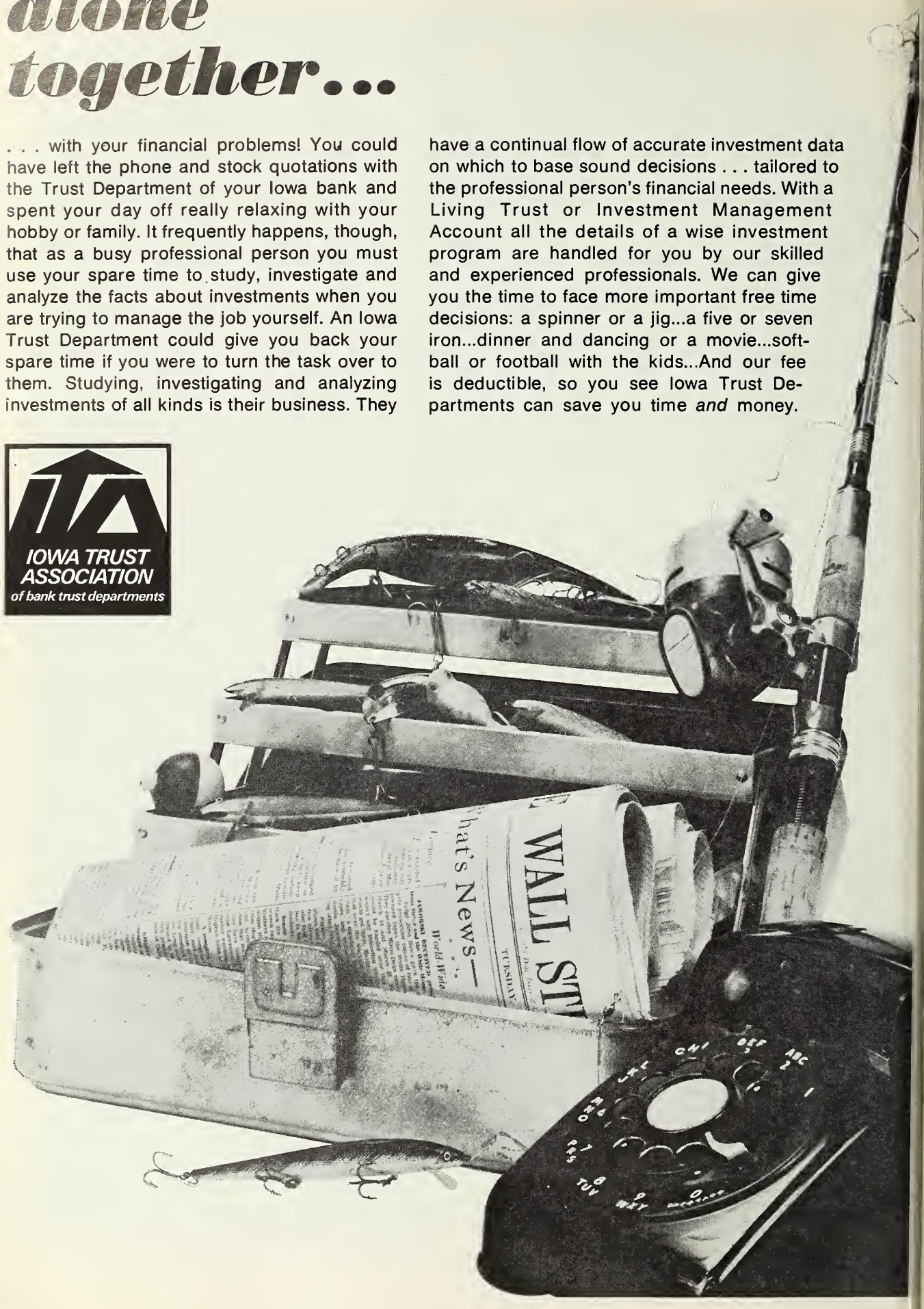

President's Address

Highlights of a Busy Year

VERNE L. SCHLASER, M.D.
Des Moines

Medical liability, HSA, PSRO, hospital staff relations, continuing medical education—these were among the key topics before the Iowa Medical Society in 1975-76. Dr. Verne Schlaser comments here on his year as president of the Iowa Medical Society.

ONE YEAR AGO I was installed as president of the Iowa Medical Society. It is hard to believe 12 months have passed since that occasion. We have covered considerable ground in the year just behind us. The developments have been both good and bad, big and small, conclusive and indefinite.

MEDICAL LIABILITY

The subject of medical liability was the most acute problem when the gavel was entrusted to me. While the situation is still clouded and critical, we have made some head-way. House File 803 was passed by the Iowa House of Representatives on May 23, 1975. It was passed by the Senate on June 5, 1975, and subsequently signed by the governor.

As you are aware, House File 803 is at best a stepping stone on the pathway to a permanent solution to the liability dilemma. It has been described as such by many informed observers—including representatives of those insurance companies that are continuing to market coverage in Iowa. We have an obligation to our professional colleagues in the so-called high-risk classifications, particularly the anesthesiologists, to find coverage options which are fair to them and their patients.

House File 803 was summarized in the December issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY. It contains the following provisions:

1. Authorization for a Joint Underwriting Association should the Insurance Commissioner decide coverage is totally unavailable in the private market.
2. Peer review immunity to assure that persons acting in good faith will not be held criminally liable for their actions.
3. Imposition of the collateral source rule which precludes a plaintiff from collecting twice for costs covered by health insurance.
4. Allowance for the optional use of a written instrument through which a physician may create a legal presumption that informed consent was given.
5. Requirement that the court shall determine the reasonableness of any contingency fee.
6. A statute of limitations requiring medical liability suits to be brought within two years of discovery and no more than six years from the act, with one or two exceptions, and
7. Elimination of the ad damnum clause which prohibits announcement of a dollar amount in a petition for damages.

The 1975 House of Delegates instructed the Board of Trustees, in consultation with the Medico-Legal and Legislative Committees, to examine the situation when adjournment of the 1975 General Assembly was at hand. The need for a special session of the House of Delegates was to be decided at that time. Out of this deliberation came the call for a special session of the House on June 8, 1975.

At the special session, the House (1) acknowledged the passage of House File 803; (2) urged the legislators to use the interim to pursue

These remarks were presented by Dr. Schlaser on May 1 at the opening session of the 1976 Annual Meeting of the Iowa Medical Society House of Delegates.

a more definitive solution, and offered the profession's expertise toward that goal; (3) directed further IMS contact with the State Insurance Commissioner to locate acceptable coverage for member physicians; and (4) reaffirmed the profession's full support of high quality medical care with peer review mechanisms to back its statements.

The Iowa General Assembly appointed an interim study committee to give further attention to the medical liability situation. This 10-member committee met frequently during the latter part of 1975 and into January of this year. The Society was present at each meeting of the interim committee and provided information and recommendations.

The eventual report of the interim committee contained several recommendations of the Iowa Medical Society and was presented to all members of the General Assembly, especially for consideration by the House and Senate Commerce Committees. Out of all this has come House File 1489 which has been recommended for passage by the House Commerce Committee. A bill (S.F. 1310) has also been brought forward by the Senate Commerce Committee.

The availability of basic limits coverage is reasonably good at this time. Aetna, Medical Protective and St. Paul are the three principal companies now marketing basic coverage. St. Paul made its conversion to the claims-made coverage last year despite a request of the Society to the Insurance Commissioner that this authorization be delayed.

In summary, the medical liability situation is still difficult. We need to make the situation known to our legislators, as it relates to the availability and cost of medical care, and we need to report our coverage problems to Society headquarters.

HEALTH PLANNING

We are now in the era of the Health System Agency or HSA. The HSA emerged this year out of Public Law 93-641. This will eventually replace all of the health planning agencies and programs which have existed. This past year has seen 90 of Iowa's counties and one Nebraska county become one health service area. The other nine Iowa counties have been grouped with either Nebraska or Illinois.

Five sub-areas have been formed under the Iowa HSA and each has its advisory council. The Iowa HSA Board of Directors includes 30 persons and five of them are physicians—4 MD's and 1 DO. The Board totally has 11 providers, 18 consumers and one member from the Veterans Administration. The five physicians are Dr. John Tyrrell of Manchester, who incidentally is the vice-chairman; Dr. Paul Seebohm of Iowa City; Dr. Larry Ely of Des Moines; Dr. Russell Gerard of Waterloo, and Dr. Roger Rademacher of Charles City.

While it has been the wise decision of the medical profession in Iowa to be involved in the state-level implementation of HSA and not to let it evolve without medical input, it is further significant to note the American Medical Association and the North Carolina Medical Association are now joining in a suit to test the legality of the federal statute which imposes this program on the states. We will follow these developments with much interest.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION

The Iowa Foundation for Medical Care was named conditional PSRO this year. It sought this designation at the urging of the House of Delegates and as the mechanism of the medical profession to comply with still further federal mandates.

The Foundation is seeking to establish affiliations with 50 Iowa hospitals in 1976. Some of these hospitals will receive delegated status and will have pretty full authority to conduct independent reviews of those individuals receiving federally funded care within their confines. Another 15 or so Iowa hospitals are expected to come into the PSRO picture in 1976 but on a less independent basis.

HOSPITAL-MEDICAL STAFF RELATIONS

During the year the Iowa Medical Society distributed to the chief of each hospital medical staff in Iowa materials pertaining to the relationships between doctors—as members of a medical staff—and the hospitals in which they work. This included a booklet from the American Medical Association, as well as the summary of a document prepared by Mr. Robert Throckmorton, the Society's legal counsel. This information is still available on request to the Iowa Medical Society.

CONTINUING MEDICAL EDUCATION

Operating as an instrument of the American Medical Association, the Medical Society moved

forward this year in its new role as an agency to receive and review requests from institutions seeking accreditation for their continuing medical education programs.

The Committee on Medical Education and Hospitals is responsible for this aspect of the Society's program. It recently completed a CME site visit and survey of Mercy Hospital in Des Moines. As a result of the application and the follow-up evaluation, it appears likely Mercy Hospital will be approved to grant Category I credit for its CME programs toward the AMA Physicians Recognition Award.

IOWA MEDICAL AUXILIARY

Among its many accomplishments this year, the Auxiliary changed its name. Instead of Woman's Auxiliary to the Iowa Medical Society, the organization is now officially the Iowa Medical Auxiliary. In a demonstration of its support for the IMS and its programs, the Auxiliary has recently voted to allocate the funds from its Health Education Loan Fund to the Scanlon Foundation. This will bring more than $20,000 additional dollars into the medical student loan program. This information is contained in the Scanlon Report and is much appreciated. The Society is grateful to President Erlene Veverka and all the Auxiliary members for this and other valuable assistance. This group is extremely active at the local, state and national levels.

COMMUNICATIONS

The Society's officers have been and are taking a look at our communications efforts. The JOURNAL, the News Bulletin and the Legislative Bulletin are provided to members. A new IMS Mini-Message has carried brief and important reports on occasion this year.

A variety of programs were conducted by the Society this year. A seminar for new Society members was held last fall and proved successful. This should be repeated and be made open to all new physicians in the state, not just those who have affiliated with the IMS. In addition, conferences were held for county society officers, for legislative contact men and for representatives of specialty organizations. We would do well to continue those events and emphasize the opportunity for give-and-take. We need to hear the problems and views of as many of our constituents as possible.

In this regard the Society's officers were pleased to receive invitations to 25 county medical society meetings during the course of the year. This afforded us an excellent opportunity to meet many of you and your colleagues in your own backyard. We have the impression the effort was well received by those at the local level. Thanks for inviting us.

CONCLUSION

Now I am going to sound like a politician. I believe the past year has been a good one for the Iowa Medical Society. And I am looking forward to the coming year with Dr. Bishop as your president—I know it will be a good one.

I wish to thank you all for the opportunity of having been your president for the past year.

IN THE PUBLIC INTEREST

(Continued from page 243)

to subordinate financial reward to social responsibility. A physician should not engage in practices for pecuniary gain that interfere with his medical judgment and skill or cause a deterioration of the quality of care. Ability to pay should be considered in reducing fees, and excessive fees are unethical.

Physicians should not pay commissions or rebates or give kickbacks for the referral of patients. Likewise, they should not make extravagant claims or proclaim extraordinary skills. Such practices, however common they may be in the commercial world, are unethical in the practice of medicine because they are injurious to the public.

Freedom of choice of physician and free competition among physicians are prerequisites of optimal medical care. The *Principles of Medical Ethics* are intended to curtail abusive practices that impinge on these freedoms and exploit patients and the public.

Installation Comments

The More Free Riders, The Harder Rest Must Row

JAMES F. BISHOP, M.D.
Davenport

Continuing difficult issues will be before the medical profession in the coming year. An active body of physicians will be needed to meet the problems. Only in this way can the interest of the public be well served.

We are all anxious to wind up the business of this interesting and productive session. I hope I will not impose too much upon your patience if I ask you to grant me a few more minutes to share a few thoughts with you.

The malpractice insurance dilemma has not been solved, only the immediate crisis somewhat allayed. The committees that have labored so faithfully to confront the problem will continue their exertions. They are, however, somewhat hampered and discouraged by the lack of help from the membership. Some legislators have said they have had few communications from the physicians of the state expressing support for the bills now in the hopper. This leads them to conclude there is no sense of urgency among the physicians and hence the legislators feel no sense of crisis. This despite several bulletins from our office asking for letters to the lawmakers.

These remarks were presented by Dr. Bishop on May 2 just after his installation as 1976-77 president of the Iowa Medical Society.

There are two other aspects of the liability insurance situation which I have emphasized around the state. Both would be helpful in reducing the total cost. The first is the need for some recourse for the successful defendant. The citizen who has been sued for damages for some wrong or injury and then is absolved of fault in the court suffers loss of time and income, great mental distress, and the cost of his defense. If the judicial process says he was wrongfully charged he should be entitled to damages from his accuser.

The second aspect, by its very nature, appeals for change. Let us suppose a patient is damaged by incompetence, negligence, or abandonment and it is determined that fair compensation for his loss is $100,000. It adds nothing to the patient's benefit if someone—physician or his insurer—has to pay an additional $50,000 for him to get it. An arbitration board and experts provided by the medical society could reach a just conclusion without the expensive exercises of the adversary system in court. I hardly expect a great wave of support for these proposals from certain members of the legal profession.

I will ask our office in Des Moines, with the Board's approval, to set up a reporting system so that we can bring together our own information. It would be most helpful if, whenever a suit is threatened, filed, or settled, in or out of court, the physician involved would submit the details of the situation to his county society secretary who would, in turn, send the report on to the IMS office. The physician involved would have an understandable reluctance to thus expose his problem but we will need factual information to carry on. There is, within our membership, a wealth of expertise in all the disciplines of medi-

cine. I am sure there are ways to organize and use this expertise in evaluating the merits of a suit and even in helping to defend it.

FLU VIRUS PROGRAM

The IMS and the Iowa Department of Health have pledged to cooperate closely in carrying out the massive flu immunization program now in the works. I have asked the ad hoc committee appointed by Dr. Schlaser to continue to function. In such a massive program involving so many people, some untoward reactions are bound to develop. We will inquire into the possible liability of physicians and the need for consent and a release from recipients of the vaccine.

HEALTH CARE COSTS

Steadily increasing health care costs continue to plague us and draw down upon our heads indignation from various sources, some of it perhaps justified. Blue Shield reports significant increases in all charges for 1975, considerably greater than the rate of inflation. Part of the increase is due to greater utilization and, certainly, to climbing malpractice insurance premiums but this is hardly the complete answer. We must keep in mind that very few patients could pay from their own resources the charges paid in their behalf by the insurance companies. This very favorable climate should not be jeopardized by headlong pursuit of the medium of exchange. If the mounting costs continue, the demand for some type of control, already being heard, will grow louder.

IMS MEMBERSHIP

Membership in the IMS has shown improvement over last year but still too many physicians remain outside our ranks. Be sure your county societies are aware that the new physician, in his first two years of his first practice, may join the IMS for one-half the usual dues or, at present, $100. I have found that news of this opportunity has not spread widely throughout the state. Remind your colleagues how important their moral and financial support are. Remind them that professionally, economically, and politically, we are all in the same boat. The more free riders there are, the harder the rest of us have to row. The medical society is not "they in Des Moines" but we in Iowa, from Hamburg to Waukon, from Keokuk to Hawarden, from Mason City to Ottumwa.

If it seems advisable, we will be back here in the Fall. Drive carefully.

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AMA Maximizing Responsiveness

FRANK A. JIRKA, M.D.
River Forest, Illinois

The American Medical Association is revitalizing itself structurally, strategically and philosophically. It is doing so in an effort to be responsive to the membership. This important exercise is achieving significant success, says an AMA trustee.

THE MULTIPLE FEDERAL assaults on the medical profession are exploiting and confusing the dynamics of change in health care, instead of relieving it. As a result, it is easy for physicians to feel a terrible sense of trauma in the face of change.

We have seen physicians overreact to change as epitomized by the scramble of some to join splinter groups. We have seen them underreact also. Some doctors feel if the windows of their offices, their inner sanctums, are closed tight enough, the winds of change will be muffled out.

Fortunately, most physicians want neither to overreact nor to underreact. They want to respond in a rational yet fervent manner which is realistic yet optimistic, and that means responding, through our national, state and local federation, to the problems that affect us as physicians, rather than simply as specialists. I submit that our federation has been the manifestation of reason, fervor, realism and a sure-footed optimism. We manifest those qualities because we know how to evaluate change, how to select and time our answers to it, how to mount our own initiatives in it, and how to enable physicians to remain the masters of their destiny regardless of change.

To deal properly with this milieu, an organization must renew itself, and the AMA has been revitalizing itself strategically, structurally, and, to some extent, philosophically.

NEGATIVE FEELING

Outside our profession, and inside it too, especially among younger doctors, the AMA's philosophy is often regarded as negativistic, and what is the principal single ground for this charge? It was and is our opposition to Medicare and similar legislation in the early 1960's.

Let's set the record straight. We were not against subsidized health care for the elderly. We were against providing it in a manner that would be opportunistic politically and unwieldly and overburdening financially.

The passing years have vindicated our objections. Medicare today pays less than one-half of the health costs of its beneficiaries. Its own runaway costs have given us the Swedish syndrome, struggling young people paying even higher taxes to help even those old people who are better off.

So who is being negativistic in the Medicare controversy? While it is untrue that we have been negativists, it is true that we are positivists today as never before. I am using the word "positivists" not just as an antonym, but in the philosophic sense propounded by the 19th Century Frenchman, Comte, who was also the founder of sociology.

"Positivism holds that the primary aim of knowledge is to establish facts in a scientific manner, and to mold those facts into premises that will guide our actions."

Comte further believes that political action has to be correlated with the needs and aspirations of society, otherwise it is isolated and insulated from real facts, and being a political conservative, he insisted that progress be orderly.

Dr. Jirka is a member of the Board of Trustees of the American Medical Association. This paper summarizes remarks made by him to the Iowa Medical Society House of Delegates on May 1, 1976.

FACTS ARE FOUNDATION

Now, how does that positivistic philosophy tie in with what our federation is doing? To begin with, facts and their logical conclusions are the very foundation of the positions we take in the full range of public affairs, as well as in medical science. Our position on National Health Insurance is based partly on foreign evidence which shows that while NHI can improve health care financially, it is likely to clutter and impede physical access.

A new and graphic example of our reliance on facts is our appointment of a National Commission on the Costs of Medical Care composed of key figures in the fields of health, insurance, government and research. The Commission will determine the reasons for rising costs, review the options for coping with them, and give the public a clearer picture of the situation.

On those and other issues it is easy to levitate above the facts, and some planners and wheeler-dealers in Washington do. It is easy to give in to angry impulses that stomp on facts, as some of us unfortunately do, but in a democratic society, whose future must depend on the rule of reason, it is essential that you and I of the AMA act authentically and reasonably. Only in that way can we physicians interrelate politically with the larger society. Only by so interrelating can we win the people's support for orderly, reasonable change in health care.

Next, how has the AMA been adapting itself strategically? As a member of our legislative department says, our strategy can be summed up by stealing a favorite line of Muhammad Ali and changing the "I" to "we." "We float like a butterfly and sting like a bee." We float, that is, until it is the right time to strike.

POLITICS IS TIMING

The art of politics is timing, not sheer muscular force.

A recommendation made by our House of Delegates in Honolulu that we work with private insurors to expand insurance or catastrophic coverage could be called good timing. Timing was important in getting the House of Representatives' version of the Health Manpower Bill amended on the floor so the federal control of residencies was stricken from it and student pay-back of federal grants to medical schools was softened. Timing was important to our projected legal challenge to the National Health Planning and Resource Development Act of 1974, and to its constitutionality. We will join the state of North Carolina in its suit against that law, which suit was filed April 27. Timing has contributed to our headway in getting the PSRO law amended.

Yes, timing is an important element of strategy, but we also appreciate the importance of selectivity and flexibility in the means to be employed. We have to know exactly what means to use or develop, and exactly how far to go with it. Sometimes we have to resort to more than one means of gaining similar objectives. All of this is dramatically illustrated in our flanking movement against the steady blitzkrieg of HEW regulation.

GOVERNMENTAL RELATIONS

Direct argument with HEW can often be futile, so we have to think about flanking movements and a new methodology, hence our landmark federal court lawsuit against the UR rules and the maximum allowable cost of drugs. In getting favorable court action that triggered the withdrawal of those UR regulations, we showed how we can sting like a bee, and I must say it was my personal pleasure and privilege to represent you in that court action.

Court action in our next suit is expected soon. Large as our lawsuits are and as prepared as we are to go all the way with them when necessary, we also have to think about additional ways of curbing government by regulation, and those ways include zeroing in on the regulatory process itself, hence the AMA has presented to Congress House Bill 10-301, which would amend the Administrative Procedure Act. The proposed amendments are complex, but in essence they would keep regulations from taking effect as hastily, capriciously and loosely as they now do.

The diversified strategy of the AMA is at work, not only against federal regulation but against the most grim of the current menaces, professional liability.

First, we are trying to keep Congress from getting into the act because all this would do would eventually restrict physicians as to where and how they practice. Secondly, we have supplied state medical societies at their request with pragmatic guidance and active help.

Thirdly, we have been forming a reinsurance company to provide a second layer of protection for those societies that sponsor malpractice insurance.

Such then is a glimpse of the AMA strategy: New style on explosive issues.

We think our strategy can be increasingly effective, but, gentlemen, let's face it: Strategy from a democratic federation such as ours can only be as influential and potent as the federation itself. That means, in part, that the current momentum for unified membership must intensify and spread. It also means some restructuring of the AMA and its governing bodies. The base of membership strength ought to be broadened so that there is a better formal and practical relationship between our federation and the ways in which medicine is practiced today.

We took a significant step in that direction when we extended to the interns and residents a voice and vote in our House of Delegates. After all, about a fifth of all physicians in patient care are house staff.

Now we have to think about giving the medical specialties a more precise and responsible means of input through their respective societies. By action of the House in Honolulu, that recommendation will be given further consideration in the months ahead.

The Delegates also voted for some streamlining of the Board of Trustees and the system of Councils so these components are better geared to the present-day needs, and, yes, your AMA has even developed a Department of Negotiations to better equip and help we physicians in protecting our vested rights, and ultimately the AMA hopes to have trained in-house negotiators at all levels of the federation.

Structurally, strategically, philosophically, the ways in which your AMA is updating itself are varied, in that they have a common bond: They signify that your AMA has moved to new heights in its responsiveness and in its sense of responsibility.

We, your elected representatives, want to be even more responsive to you and for you, but let's face the hard truth, the stern truth, that responsiveness in a federation like ours cannot be one-sided. It is dependent upon our sense of solidarity with your county, your state and the AMA, and, gentlemen, last but not least, on your physical, moral and financial support.

God bless you. May you have a very wonderful, productive House of Delegates meeting. It is a pleasure to be here today.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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State Department of Health

SWINE FLU INFORMATION

The Iowa Medical Society is working cooperatively with the State Department of Health in the coordination of the 1976 Iowa Program for Vaccination Against Swine-like Flu. The recommended strategy for the Iowa Program, as approved by the IMS House of Delegates in May, appeared in the June issue of the JOURNAL. *Following is additional basic information excerpted from the June 4 issue of the Morbidity and Mortality Weekly Report prepared by the U. S. Center for Disease Control.*

INFLUENZA VIRUS VACCINES FOR 1976-1977

The National Influenza Immunization Program provides for two vaccine formulations: a bivalent vaccine for the traditionally identified "high-risk" groups and a monovalent vaccine for the rest of the population. The bivalent vaccine will contain both A/Victoria/75 and A/New Jersey/76 (the swine influenza virus) because the A/Victoria strain which was prevalent in 1975-1976 may persist to some extent in 1976-1977. The monovalent vaccine will contain only the A/New Jersey/76 strain. Vaccines will begin to become available during the summer.

In addition to the influenza A vaccines provided in the National Influenza Immunization Program, there will be a monovalent influenza B vaccine. It will be available through regular commercial channels for persons in the high-risk groups for whom annual influenza vaccination is regularly recommended.

SWINE INFLUENZA VACCINE USAGE

GENERAL RECOMMENDATIONS

High-Risk Groups: Bivalent influenza A vaccine is recommended for persons of all ages who have such chronic health problems as 1) heart disease of any etiology, particularly with mitral stenosis or cardiac failure, 2) chronic bronchopulmonary diseases, such as asthma, chronic bronchitis, cystic fibrosis, bronchiectasis, tuberculosis, and emphysema, 3) chronic renal failure, and 4) diabetes mellitus and other chronic metabolic disorders.

Bivalent influenza A vaccine is also recommended for older persons, particularly those over age 65 years. This is because excess mortality in influenza outbreaks is seen among those in the older age groups as well as among patients with chronic illnesses.

General Population: Monovalent A/New Jersey/76 (swine influenza virus) vaccine is recommended for all persons not in the high-risk groups who can safely and effectively be vaccinated. Age criteria for vaccine recipients will be derived from the field trials being conducted at the present time and will be included in the final ACIP influenza statement to be published in July 1976.

Information for Vaccinees: Influenza vaccination should be preceded by informing all potential recipients or the parents of children to be vaccinated of the general characteristics of the vaccine, what its benefits are, and what side effects it has. Comparable procedures for providing this information should be used. There should be ample opportunity for recipients to have their questions answered, and there should be documentation that information was received and vaccination desired. Documentation could be by the signature

of potential recipients or of parents or guardians or by other systems of records judged sufficient to identify those who, after being informed, choose to be vaccinated.

DOSAGE AND SCHEDULE

Only one dose of the bivalent vaccine or the monovalent influenza A vaccine should be needed. Age criteria, proper dosages, and routes of administration will be derived from field study results. Influenza vaccination programs should begin as vaccines become available and should continue through the fall so that the target population can be vaccinated before winter, the season when influenza characteristically occurs.

SIDE EFFECTS

Influenza vaccines currently produced by manufacturers in the United States are purified by zonal centrifugation and should produce few severe side effects. Before these new purification techniques came into general use in the late 1960s, influenza vaccines fairly commonly caused local and systemic reactions considered objectionable by many recipients. With current influenza vaccines, however, only mild local reactions, such as erythema and tenderness at the injection site, will be relatively common. Systemic reactions, including low-grade fever, chills, malaise, or headache, should occur only infrequently. These conclusions are based on experience with influenza vaccines similar to the ones that will be used this year. Data from field trials with the actual 1976-1977 vaccines will help delineate side effects.

PRECAUTIONS

Persons with known hypersensitivity to egg protein should not be given influenza vaccine except under the close supervision of a physician.

CONCURRENT ADMINISTRATION OF INFLUENZA AND OTHER VACCINES

It would seem prudent not to administer influenza vaccine along with vaccine containing diphtheria, pertussis, or tetanus antigens since fever is often associated with these antigens, and their simultaneous administration might increase the chance of febrile responses. Furthermore, influenza vaccine should probably not be administered within 14 days after vaccination with the live, attenuated measles virus vaccine since measles vaccine is known to induce fever in 15 percent or more of vaccinees beginning about 6 days after vaccination and lasting several days.

If, in the context of the National Influenza Immunization Program, health agencies plan to provide vaccines other than those against influenza, they should take into account such matters as the risk of coincidental vaccine reactions, the need for informing recipients about all antigens to be given and for documenting vaccine acceptance, and the record-keeping commitments that giving multiple antigens entail.

Every effort should be made during the period of the National Influenza Immunization Program to maintain routine vaccination activities and to conduct whatever programs are needed to prevent and control outbreaks of vaccine-preventable illnesses.

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Union-Taylor	Jed Paul, Creston	L. W. Goetz, Creston
Van Buren	Kiyoshi Furumoto, Keosauqua	J. T. Worrell, Keosauqua
Wapello	R. D. Schrantz, Ottumwa	R. P. Meyers, Ottumwa
Warren	Amalgamated with Polk County	
Washington	E. M. Ahart, Washington	G. J. Nemmers, Washington
Wayne	K. A. Garber, Corydon	K. A. Garber, Corydon
Webster	H. H. Allen, Fort Dodge	R. B. Wyatt, Fort Dodge
Winneshiek	P. J. Callaghan, Decorah	D. R. Bakken, Decorah
Woodbury	L. H. Boggs, Sioux City	J. W. Scott, Sioux City
Worth	W. G. McAllister, Manly	B. H. Osten, Northwood
Wright	G. B. Hogenson, Eagle Grove	C. P. Hawkins, Clarion
Student IMS	Karen Weihs	Ann Goodenberger

OFFICIAL PROCEEDINGS

1976 HOUSE OF DELEGATES
MAY 1-2, 1976
DES MOINES, IOWA

(Alphabetical Index—Page 315)

SATURDAY SESSION, May 1, 1976

The House of Delegates of the Iowa Medical Society was called to order by the Speaker, L. D. Caraway, M.D. of Amana, at 9 a.m., Saturday, May 1. The House approved the taking of attendance by signed registration cards. There were 112 delegates, 16 voting alternates and 13 ex-officio members present.

COUNTY	DELEGATE
Appanoose	A. S. Owca
Black Hawk	C. D. Ellyson
	R. S. Gerard
	R. T. Guthrie
	W. M. Kelly
	A. M. Dolan*
Boone	E. E. Linder
Bremer	G. J. Kimball
Buchanan	P. J. Leehey
Cerro Gordo	W. G. Garrett
	R. E. McCoy
	R. M. Powell
	W. C. Rosenfeld
	D. D. Van Etten
Cherokee	G. E. Michel
Chickasaw	J. C. Carr*
Clay	J. X. Tamisiea
Clayton	J. D. Compton
Clinton	G. T. Schmunk
Crawford	D. J. Soll
Dallas-Guthrie	N. L. Krueger
	E. E. Lister
Davis	H. M. Perry
Decatur-Ringgold	D. E. Mitchell
	T. R. Viner
Delaware	J. E. Tyrrell
Des Moines-Louisa	K. A. Hahn
	R. J. Rettenmaier
	J. P. Stoikovic
Dickinson	D. F. Rodawig, Jr.
Dubuque	J. S. Chapman
	K. K. Hazlet
	R. T. Melgaard
	J. W. White
Fremont	F. M. Ashler
Grundy	D. R. Kruschwitz
Hamilton	G. A. Paschal
Hardin	T. C. Graham
Harrison	J. W. Barnes
Humboldt	J. H. Coddington
Ida	J. B. Dressler
Jasper	T. E. Kiernan
Jefferson	T. J. Sutton
Johnson	R. C. Brown
	K. D. Dolan
	S. W. Greenwald
	C. E. Hartford
	K. J. Judiesch
	K. J. Printen
	C. E. Radcliffe
	R. E. Rakel
	R. D. Whinery
Jones	A. P. Randolph
Kossuth	J. M. Rooney
Lee	J. E. McGee
	G. C. McGinnis
	R. L. Kent*
Linn	R. W. Conkling
	J. H. Lohnes
	R. A. Sautter
	G. R. Wessel
Marion	J. M. Dockum, D.O.*
Mahaska	S. A. Smith
Marshall	L. O. Goodman
	J. W. Hughes*
	R. R. Widner
Mitchell	R. G. Boeke
Monona	J. L. Garred
Muscatine	K. E. Wilcox
O'Brien	R. L. Zoutendam
Osceola	S. R. Helmers
Page	J. R. Gambill
Plymouth	J. P. Trotzig
Pocahontas	J. M. Rhodes, Sr.
Polk	Lester Beachy
	D. B. Dorner
	W. K. Downing
	J. L. Fatland
	Marshall Flapan
	John Hess, Jr.
	J. I. Hostetter
	J. J. Kelso
	R. L. Kollmorgen
	L. E. Longnecker
	J. W. Olds
	L. J. Plummer
	J. J. Polich
	D. C. Young
	M. H. Dubansky
	D. J. Walter
	C. H. Denser, Jr.*
	H. G. Ellis*
	L. O. Ely*
	C. N. Hull*
	D. L. Sweem*
	D. J. Tesdall*
	B. T. Woodburn*
Pottawattamie-Mills	J. L. Knott
	E. B. Mathiasen
	L. L. Leibel*
	M. E. Olsen
Poweshiek	H. R. Light
Scott	J. C. Barker
	Gordon Cherwitz
	W. B. Hofmann
	R. J. Ketelaar
	D. L. Miller
	R. M. Perkins, III
	F. W. Smith
Shelby	J. H. Spearing
Sioux	E. B. Grossmann, Jr.
Story	W. A. Baird
	W. R. Bliss
	Charles Jons
	A. J. Havlik
Tama	R. H. Kuhl
Union-Taylor	K. E. Lister
Wapello	R. D. Schrantz*
	Leonard Lamberty
Winneshiek	R. A. Boldus
Woodbury	J. S. Pennepacker
	D. M. Youngblade
	J. M. Krigsten*
Wright	A. F. Benetti
Student IMS	D. C. Trost
	James Dennert*

*Alternate

LIAISON DELEGATES

C. W. Seibert J. D. Ver Steeg

EX-OFFICIO MEMBERS OF THE HOUSE

V. L. Schlaser C. E. Radcliffe
J. F. Bishop J. R. Anderson
J. H. Kelley J. R. Scheibe
Hormoz Rassekh R. L. Wicks
A. L. Sciortino J. W. Eckstein
L. D. Caraway J. H. Sunderbruch
L. W. Swanson

W. R. Bliss, M.D., Secretary of the Society, moved the minutes of the May 1, 1975 session of the House of Delegates be approved as published in the July, 1975 issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY. The motion passed.

Dr. Caraway introduced those individuals at the head table and welcomed delegates serving for the first time. He stressed the responsibility of the delegates to their constituents not only at the House of Delegates meeting but also as a year-round duty; he then explained the voting procedure of the House and introduced members of Reference Committees. Dr. Bliss moved the reports of the HANDBOOK FOR THE HOUSE OF DELEGATES be approved as published with the following exception—pages 47 to 48 of Committee on Delivery of Health Services be referred to Reference Committee on Reports of Officers and Miscellaneous Business.

Reports of Officers

FROM THE OFFICE OF THE SECRETARY

The Secretary of the Iowa Medical Society is responsible for maintaining membership and dues records; conducting the official correspondence, notifying members of meetings, officers of their election, and committee members of their appointments and duties; and preparing minutes of all official meetings. Assistance is also provided to the district councilors in organizing and improving the component societies, and in extending the usefulness of the IMS.

HOUSE OF DELEGATES

Proceedings of the 1975 Annual Meeting of the House of Delegates were published in the July 1975 issue of the IMS JOURNAL. The necessary administrative procedures have occurred to implement the directives of the delegates.

District councilors have received assistance from IMS staff in organizing their caucuses in preparation for the 1976 Annual Meeting and in preparing for the meeting of the Nominating Committee scheduled March 28.

ANNUAL SCIENTIFIC PROGRAM

The 1976 Annual Scientific Program will be in Iowa City, Iowa, April 6-8. A summary of the program was published in the March issue of the IMS JOURNAL. The program has been approved for 14 prescribed hours by the American Academy of Family Physicians and Category I Credit/AMA Physicians Recognition Award.

EXECUTIVE COUNCIL

Three meetings of the Executive Council have been held since the final session of the House of Delegates in 1975, and a fourth is scheduled on April 6. The Council is the interim policy-making body which meets between sessions of the House to act on important issues.

JUDICIAL COUNCIL

The Judicial Council met three times the past year, and a fourth session is scheduled in April. Whenever possible, the Board of Trustees and Judicial Council arrange a joint dinner prior to Executive Council sessions so that topics of general interest can be discussed.

The principal responsibilities of the Judicial Council are (1) to approve applications for IMS membership; (2) to consider various questions regarding membership or ethics; and (3) if necessary, to discipline members of the Society.

A report from the Judicial Council appears elsewhere in the Handbook.

BOARD OF TRUSTEES

Regular meetings of the Board of Trustees are held monthly and special meetings are called as necessary. The Board is responsible for conducting the business of the Society, and there is almost daily communication between IMS staff members and the President, Chairman of the Board, and other IMS officers.

COMMITTEES

There are 20 standing and 25 special committees of the IMS. Over 30 official meetings have been held since the House of Delegates adjourned its final session last May. Additional committee meetings are scheduled prior to the opening session of the 1976 House of Delegates.

In addition to formal committee work, staff members maintain regular contact with committee chairmen and members by telephone and personal visitation to carry out specific projects and activities.

The Society is represented on councils and committees of various state and voluntary agencies, e.g., the Iowa Regional Advisory Group, the Advisory Council to the Office for Comprehensive Health Planning, Iowa's Health Systems Agency, Advisory Committee on Emergency Medical Services, Advisory Committee on Physicians' Assistants Program, the Iowa Health Council, Advisory Council on

Family Practice Residencies, State Drug Abuse Advisory Council, Commission to Study Nursing in Iowa, Advisory Committee for Family Nurse Practitioners, etc.

NATIONAL, REGIONAL AND STATE CONFERENCES

The Trustees have been selective in authorizing IMS representation at national, regional and state conferences. The Trustees believe gathering and exchanging information on medical programs and issues are important and beneficial to the Society. IMS representatives attended national conferences dealing with medical education and continuing medical education, rural health projects, professional liability, legislation, political action, and other important subjects.

IOWA REPRESENTATION AT THE NATIONAL LEVEL

Close liaison between the IMS and AMA is maintained at both the officer and staff level. Several IMS members serve on AMA councils and committees, including the following: Jack Moyers, M.D., Iowa City, Residency Review Committee-Anesthesiology; B. F. McCabe, M.D., Iowa City, Residency Review Committee-Otolaryngology; Herman J. Smith, M.D., Des Moines, Council on Constitution & Bylaws; George Penick, M.D., Iowa City, Archives of Pathology; Craig Ellyson, M.D., Waterloo, Joint Commission on Health Problems in Education of NEA and AMA; Roger Simpson, M.D., Iowa City, Interspecialty Council, American Academy of Otolaryngology; Maurice Van Allen, M.D., Iowa City, Interspecialty Council, American Academy of Neurology; Scientific Section Council Officers —Paul Seebohm, M.D., Iowa City, American Academy of Allergy; Carl Graf, M.D., Iowa City, American Association of Neurological Surgeons; David Culp, M.D., Iowa City, American Urological Association; George Bedell, M.D., Iowa City, American Thoracic Society.

STAFF

Eldon E. Huston was named Executive Vice President of the IMS last June, succeeding Donald L. Taylor, who continues to serve the Society as an Executive Advisor. As Executive Vice President, Mr. Huston maintains close contact with the Provider Service Division of Blue Cross/Blue Shield, which includes both hospital and physician relations. This division has six physician relations representatives who, with direction from the IMS, maintain personal contact with physicians throughout the state and provide a valuable service to them, as well as to organized medicine and Blue Shield. The representatives operate in designated regions and, according to comments from physicians, they function effectively and provide valuable information and assistance.

COMMUNICATIONS

The Iowa Medical Society communicates regularly with the membership to apprise Iowa physicians (1) of the many projects and programs undertaken by the Society, and (2) of its position on the numerous issues which confront medicine. Following are some of the communications published and/or distributed through the Society:

1. **IMS JOURNAL**—to all members; subscribers; clinical departments at the University of Iowa College of Medicine as a reference for residents, interns and medical students; also, exchange copies with other medical journals.

2. **IMS NEWS BULLETIN**—to all members, plus a selected group of allied health representatives. Bulletins reporting on IMS and AMA annual meetings are sent to all medical students at the University of Iowa College of Medicine.

3. **LEGISLATIVE BULLETIN**—to L.C.M.'s, Legislative Committee members, Executive Council, IMPAC Board of Directors, county society presidents, various allied health personnel, and to all IMS members when appropriate.

4. **IMS REPORT**—to all state and county medical society officers; to all medical students at the University of Iowa College of Medicine; to all of the previous year's graduates who are in postgraduate training in various hospitals throughout the country.

5. **IN THE PUBLIC INTEREST**—reprints to all members of the Iowa Press and Iowa Daily Press Associations; all members of the Iowa General Assembly; members of the IMS Auxiliary.

6. **IMS AUXILIARY NEWS**—to all members of the IMS Auxiliary.

7. **AMERICAN MEDICAL NEWS**—to all members of the Iowa General Assembly.

8. **AMA EXECUTIVE VICE PRESIDENT'S LETTER**—to all members of the Executive Council.

IMS MEMBERSHIP

Iowa Medical Society membership for 1975 totaled 2,373. Of this number, 180 held active dues-exempt membership (100 life members, 72 residents, and 8 members in military service), and 106 associate members were exempt from the payment of dues. There were 43 counties (in 42 single or two-county societies) in which 100 per cent of the county society members held membership in the IMS. There were 316 eligible non-members in Iowa. The percentage of eligible physicians who held IMS memberships was 88 for the year.

COUNTY SOCIETIES HAVING 100 PER CENT MEMBERSHIP IN IMS IN 1975

Adair	Dickinson	Kossuth
Adams	Emmet	Lyon
Appanoose	Franklin	Marshall
Audubon	Fremont	Monona
Boone	Greene	Montgomery
Bremer	Grundy	O'Brien
Butler	Hamilton	Pocahontas
Cedar	Hardin	Shelby
Chickasaw	Harrison	Tama
Clarke	Ida	Union-Taylor
Clay	Jasper	Van Buren
Crawford	Jefferson	Wayne
Davis	Jones	Worth
Delaware	Keokuk	Wright

1975 IMS MEMBERSHIP RECORD

Component Society	Active Members	Life Members	Associate Members	Eligible Non-Members	Percentage
Adair	1	..	..	..	100
Adams	2	..	..	..	100
Allamakee	6	1	..	2	78
Appanoose	5	1	2	..	100
Audubon	2	1	..	..	100
Benton	7	..	..	2	78
Black Hawk	124	4	6	5	96
Boone	16	..	3	..	100
Bremer	11	..	1	..	100
Buchanan	11	..	..	5	69
Buena Vista	8	1	1	3	77
Butler	5	..	..	..	100
Calhoun	7	1	..	3	73
Carroll	14	4	2	4	83
Cass	11	..	..	2	85
Cedar	4	..	..	..	100
Cerro Gordo	77	5	4	1	99
Cherokee	16	2	..	6	75
Chickasaw	6	..	2	..	100
Clarke	3	2	..	..	100
Clay	13	..	..	..	100
Clayton	8	..	1	1	90
Clinton	26	..	1	20	57
Crawford	9	..	..	..	100
Dallas-Guthrie	15	1	1	5	77
Davis	15	..	3	..	100
Decatur-Ringgold	6	..	1	1	88
Delaware	7	..	..	..	100
Des Moines-Louisa	36	4	3	7	86
Dickinson	6	..	1	..	100
Dubuque	50	1	2	34	60
Emmet	11	1	..	..	100
Fayette	12	1	2	3	83
Floyd	9	2	2	3	81
Franklin	1	..	1	..	100
Fremont	4	..	..	..	100
Greene	8	..	..	..	100
Grundy	7	..	..	3	100
Hamilton	6	..	2	..	100
Hancock-Winnebago	8	..	..	1	89
Hardin	13	..	2	..	100
Harrison	6	..	1	..	100
Henry	7	..	..	7	50
Howard	6	..	1	1	88
Humboldt	3	..	2	1	83
Ida	1	..	..	..	100
Iowa	5	1	..	2	75
Jackson	10	1	..	3	79
Jasper	17	1	1	..	100
Jefferson	9	1	1	..	100
Johnson	299	1	..	63	83
Jones	7	..	..	..	100
Keokuk	4	1	2	..	100
Kossuth	8	..	2	..	100
Lee	37	2	2	1	98
Linn	151	5	7	15	92
Lucas	2	1	..	1	75
Lyon	4	..	..	..	100
Madison	3	..	..	1	75
Mahaska	13	3	..	2	89
Marion	10	1	..	3	79
Marshall	45	1	..	..	100
Mitchell	7	..	1	1	89
Monona	6	..	..	..	100
Monroe	3	..	..	1	75
Montgomery	8	2	..	..	100
Muscatine	15	1	2	2	90
O'Brien	9	2	..	..	100
Osceola	1	..	..	3	25
Page	16	1	..	2	89
Palo Alto	3	1	..	2	67
Plymouth	10	..	..	1	91
Pocahontas	5	1	..	..	100
Polk	322	23	15	46	89
Pottawattamie-Mills	68	1	4	3	96
Poweshiek	9	..	..	4	69
Sac	..	..	1	5	17
Scott	100	6	3	17	87
Shelby	6	..	..	..	100
Sioux	13	..	1	1	93
Story	55	1	8	7	90
Tama	5	..	..	..	100
Union-Taylor	13	..	..	..	100
Van Buren	2	..	..	..	100
Wapello	30	1	3	1	97
Warren amalgamated with Polk					
Washington	6	..	..	1	86
Wayne	2	..	..	..	100
Webster	45	..	1	5	90
Winneshiek	11	1	1	1	93
Woodbury	105	6	4	2	98
Worth	3	..	..	..	100
Wright	11	2	..	..	100
Student IMS	25	..	..	..	..
TOTALS	2,167	100	106	316	88

REPORT OF THE TREASURER

The following financial statement reflects the fiscal status of the Iowa Medical Society as of December 31, 1975.

The 1975 income exceeded expenses by $12,229.41.

Current Assets:		
IMS Checking Accounts		$ 48,278.20
Pension and Disability Insurance Due from Employees		308.98
Investments		112,172.53
Short-term Investments		375,000.00
Accounts Receivable		38,750.00
TOTAL CURRENT ASSETS		$574,509.71
LIABILITIES AND NET WORTH		
Liabilities:		
Accounts Payable		$ 1,258.90
Accrued Personal and Property Tax		14,000.00
Deferred Compensation		112,172.53
Deferred Income		375,000.00
Due to Employees		7,606.76
TOTAL LIABILITIES		$510,038.19
Fixed Assets:		
Land		$ 74,216.96
Building	$308,264.76	
Office Furniture & Equipment	39,899.92	
Less: Reserve for Depreciation	282,165.00	$ 65,999.68
Net Fixed Assets		$140,216.64
TOTAL ASSETS		$714,726.35
Net Worth:		
Balance 1-1-75	$192,458.75	
Add: Net Excess of Income over Expenses 12-31-75	12,229.41	
Balance Net Worth		$204,688.16
TOTAL LIABILITIES AND NET WORTH		$714,726.35

IOWA MEDICAL SOCIETY
STATEMENT OF INCOME AND EXPENSES
For the Year Ended December 31, 1975

Income for the Year 1975:	
Dues—State Society	$403,442.50
Interest and Dividends on Investments	16,393.32
Miscellaneous	741.60
AMA Collection Commissions	1,837.10
Gain on Sale of Stock	11,711.69
TOTAL INCOME	$434,126.21
Expenses for the Year 1975:	
Annual Scientific Meeting (Net)	$ 10,043.53
Council Expense	2,959.04
County Society Services	6,866.09
Depreciation—Building & Equipment	39,600.00
Dues and Subscriptions	2,515.75
Employee Pension, Disability & Health Programs	20,519.12
Field Service	11,855.84
General Administrative Expense	3,518.26
House of Delegates	4,668.55
Insurance	3,603.62
Journal (Net)	19,955.90
Legal Expense	11,360.86
Lights, Gas & Water	7,378.05
Office Stationery & Supplies	8,297.24
Postage	9,466.43
Repairs & Maintenance	9,648.11
Salaries (Net)	139,800.70
Service Contracts—Machines	1,246.55
Taxes:	
Personal & Property	11,707.07
Social Security & Unemployment	7,647.78
Telephone & Telegraph	10,807.41
Travel—Officers	11,214.66
Travel—Salaried Employees	13,349.99
Trustee Expense	5,912.56
IMS Auxiliary	8,381.79
Committee Expense	39,571.90
TOTAL EXPENSE	$421,896.80
Net Excess of Income over Expenses for 1975	$ 12,229.41

THOMAS A. BURCHAM, M.D., *Treasurer*

BOARD OF TRUSTEES

The Board of Trustees is responsible for conducting and overseeing the business affairs of the IMS. The Board also oversees the implementation of the various projects and activities of the Society, which are carried out under policies established by actions of the House of Delegates.

The Board meets once each month, and almost daily contact is maintained between IMS staff members and appropriate officers.

An up-to-date summary of Society finances and programs will be presented at the opening session of the 1976 House of Delegates.

A. J. HAVLIK, M.D., *Chairman*

REPORT OF THE JUDICIAL COUNCIL

The Judicial Council of the Iowa Medical Society has met three times during the 1975-76 year. A fourth meeting is scheduled prior to the annual session of the House of Delegates. The usual and important membership responsibilities ascribed to the Council in the Articles of Incorporation and By-Laws have received careful attention throughout the year.

In accordance with custom, the 12 councilors have given individual attention to ethical questions arising within their districts. The councilors have sought to resolve these questions or concerns whenever possible through individual and informal attention. This is done in the hope of avoiding referral to a formal meeting of the Council.

The Judicial Council has considered the following matters in its deliberations this year:

**Peer Review & Quality Assurance*—The Council has reviewed and approved an IMS report which summarizes the activities of the medical profession in the areas of peer review, quality assurance and physician discipline. The report contained references to hospital medical staffs, the Iowa Foundation for Medical Care, the Grievance Committee, the Judicial Council and the State Board of Medical Examiners.

**Handling of Half-Dues*—The Council has provided guidance to staff in the administrative handling of the half-dues provision which is available to IMS members in their first two practice years. This provision was authorized by the House of Delegates in 1974. The following interpretation has been made: "For the first year of IMS membership, the level of half-dues will be based on the date of entry into membership with the normal quarterly proration to occur in setting the amount. The full second-year dues will be paid at an amount exactly one-half of that paid by active members. The following year, with dues payable January 1, the amount paid by active members will be charged."

**Unified Membership*—This concept is used in several states and mandates physician membership at the several professional levels, i.e., county, state and AMA. The Council has studied the approach but is not considering any recommendation at this time.

**Advertising by Professionals*—The Council has made brief evaluation of the complaint filed by the Federal Trade Commission against the New Haven County Medical Association, the Connecticut State Medical Society and the AMA alleging the Principles of Medical Ethics prevent or hinder competition between medical doctors and is in violation of law. Preliminary consideration has been given to the idea of a joint committee of physicians and attorneys to evaluate developments in this area.

**Physician Letters to Colleagues*—The Council has evaluated various types of letters, e.g., season's greetings, new procedures, etc., sent by physicians to colleagues. Use of this approach, however well intended, has been questioned by the Council.

**Telephone Listings*—The Council has communicated to Northwestern Bell Telephone its thinking with respect to yellow-page listings. The Council has endorsed the AMA-proposed listing of specialties but has called attention to several omissions.

Physician/Pharmacist Code—The Council has concerned itself with matters in this area on an ongoing basis and is pleased to note the revision and reprinting of this Code. The Code has been distributed in folder form to all members of the IMS and the Iowa Pharmaceutical Association.

The Judicial Council has devoted a considerable amount of time this year to membership recruitment and retention. A regular program of contact with new physicians exists and includes letters of welcome and personal visitation. The councilors are anxious for constituent physicians to be aware of their availability to discuss questions and concerns.

As this report is prepared, the councilors are conducting the district caucuses in preparation for the 1976 deliberations of the IMS Nominating Committee. The 12 district caucuses provide an opportunity to discuss potential candidates for IMS offices in addition to possible resolutions to be considered at the 1976 session of the IMS House of Delegates.

J. E. TYRRELL, M.D., *Chairman*

Reports of Standing Committees

COMMITTEE ON ARTICLES OF INCORPORATION AND BY-LAWS

No matters have been submitted to the Committee for study and review so the Committee has nothing to report. If any amendments or additions are proposed prior to the House of Delegates, the Committee will develop them for presentation to the House.

K. J. JUDIESCH, M.D., *Chairman*

REPORT OF THE GRIEVANCE COMMITTEE

During the past year, seven cases were reviewed by the Grievance Committee and five have been resolved. Two will be brought to a conclusion shortly. The number of cases referred to the Committee continued to be low in number.

S. E. ZIFFREN, M.D., *Chairman*

COMMITTEE ON HEALTH EDUCATION

For several years, your Committee chairman has been privileged to serve as a member of the Joint Committee on Health Problems in Education of the American Medical Association and National Education Association. This is a coordinating and liaison body which affords physicians and educators the opportunity to confer on matters related to the health of children and youth. The joint committee considers problems and matters that have medical and educational implications, and its pronouncements and resolutions have been used effectively to guide the development of school health programs.

The sixth edition of the book entitled HEALTH EDUCATION was developed and published by the joint AMA/NEA Committee and the "Iowa Growth Chart for Boys and Girls" was also updated. The last revision of the Growth Chart occurred in 1929.

IMS staff responds to numerous requests received from civic clubs, school teachers, and students, etc., for various films and written materials on health subjects. The IMS also secures physicians to speak at both professional and lay group meetings.

The Committee is available to assist county medical societies and individual physicians with special health education programs for use in the schools, or in the mass communications field.

C. D. ELLYSON, M.D., *Chairman*

NECROLOGY COMMITTEE

The following members of the Iowa Medical Society died during 1975:

	Age
Robert B. Allender, Des Moines	53
Clifford V. Bowers, Sioux City	63
Harry Burns, Des Moines	82
Leroy F. Catterson, Oskaloosa	77
Robert J. Dawson, Estherville	45
Rubin H. Flocks, Iowa City	69
Warren H. Foster, Clinton	80
Louis Goldberg, Des Moines	64
Solomon Greenhill, Des Moines	70
John S. Greenleaf, Iowa City	56
Roy C. Gutch, Knoxville, Tennessee	87
Cluley C. Hall, Maynard	87
Conreid R. Harken, Osceola	90
William H. Harper, Jr., Keokuk	50
William R. Hornaday, Sr., Des Moines	85
LeRoy E. Jensen, Audubon	81
Benjamin L. Knight, Cedar Rapids	82
Richard F. Looker, Cedar Rapids	54
Luther W. Loving, Estherville	84
George C. McCreight, Carmel Valley, California	87
John C. McKitterick, Burlington	78
Otis P. Morganthaler, Sioux Narrows, Ontario	85
Robert C. Mugan, Sioux City	61
Robert W. Myers, Clear Lake	54
Ezra G. Nafziger, Sioux City	53
Harold R. Peasley, Des Moines	82
Frank L. Poepsel, West Point	74
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COMMITTEE ON LEGISLATION

The year 1975 was a busy, often hectic year legislatively. A brief recap seems in order before discussing what promises to be an active year in 1976.

On national legislation, most of the IMS activity took the form of reaction to and planning because of the passage late in 1974 of the National Health Planning and Development Act. IMS activities in this area were rewarded by the naming of several IMS members to prominent positions in the new health system. Complete details can be found in the Handbook report of the Committee on Delivery of Health Services.

Members of the IMS Committee on Legislation and the IMS Medico-Legal Committee were active in the Iowa General Assembly where much of the activity revolved around the promotion of several bills designed to offer relief in the important area of medical liability.

The IMS medical liability bills were eventually merged into a single bill which became House File 803. The efforts of many individuals, among them sympathetic legislators, members of the IMS Committee on Legislation, the IMS Medico-Legal Committee, and IMS Legislative Contact Men, brought about the passage of HF 803 in both houses of the Iowa General Assembly.

House File 803 does not provide all the answers to the medical liability problem and it was not designed to do so. The authors of 803 hoped that the passage of the several measures would assure that insurors would continue to market insurance and that the reforms would be a start on solving the long-range problem of coverage cost. Results seem to indicate that insurors will continue to market in Iowa and most observers feel the passage of HF 803 in Iowa helped ease the problem, especially in the area of availability of coverage.

Nationally, 1976 promises continued study and months of testimony on both national health insurance and national health manpower planning.

Much of the debate on national health insurance continues to center around some type of catastrophic coverage.

Experts are a common commodity when it comes to advice on health manpower. Most of these experts propose one type or another of mandatory coverage for "undermanned" areas. The danger to medicine seems to be tying this mandatory coverage to unrelated medical issues such as student loans, medical school appropriations, or professional licensure.

In the Iowa General Assembly, 1976 offers much in the way of opportunity as well as the promise of a few problems.

During the 1975 session, it became obvious that medical liability could easily take the whole time of the Committee on Legislation. It would have been easy and perhaps justifiable to spend all of the Committee's time and effort on this one issue. Because the Committee must be alert to all issues, a special Executive Committee on Medical Liability was formed. This committee includes the Chairmen of the Committee on Legislation, the Medico-Legal Committee, and the Chairman of the IMS Board of Trustees.

Priority items for 1976 are: *Medical Liability*—Several IMS recommendations were made to the Legislative Interim Study Committee on medical liability. These recommendations have been introduced as individual bills. (1) Amend Iowa statutes to allow for prospective arbitration, (2) Notice of intent to sue, (3) Reversionary trust with periodic payments, (4) Limitation on non-economic (pain and suffering) loss. In addition to these measures, IMS continues to investigate other sources for excess coverage. This includes self-insurance measures such as an excess fund.

Other positive IMS Committee on Legislation priorities include adequate funding for the Family Practice Residency Program, reasonable control of radiation devices, identification of organ donors by drivers license decals, permissive and meaningful continuing medical education.

Possible defensive priorities include legislation to modify the corporate practice rule, use of drugs by optometrists, unreasonable legislation with regard to drug bioequivalency, expansion of the scope of chiropractic.

The IMS Committee on Legislation monitors bills daily and is alert to any new bill that affects medicine or any amendment to an existing bill that changes the intent of that bill. The Committee works closely with other IMS committees that have a particular interest or expertise on a given subject and is in regular contact with the IMS leadership and the IMS Legislative Contact Men. It should once again be emphasized that any success enjoyed by the Committee is because of a total team effort.

DONALD C. YOUNG, M.D., *Chairman*

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

In accordance with an action of the 1975 House of Delegates, and with approval of the AMA Council on Medical Education, the IMS, through its Committee on Medical Education and Hospitals, has authority to accredit qualified Iowa institutions and organizations which conduct continuing medical education programs for physicians. Once an institution is accredited, its CME programs are automatically eligible for Category I Credit/AMA Physicians' Recognition Award.

Last fall, an informational brochure on the accreditation program was mailed to the chiefs of all Iowa hospital medical staffs, to medical specialty organizations, and to voluntary health associations. Several have expressed an interest in the project, and one institution is presently seeking accreditation.

The Committee believes this is an important and worthwhile service of the IMS, and hopes other institutions in Iowa will seek CME accreditation.

Early in December, the IMS mailed the AMA book, "Physician-Hospital Relations/1974," to the chiefs of all hospital medical staffs in Iowa, along with a summary of a paper prepared by IMS legal counsel on the subject, "The Medical Staff and the Hospital." The full text of the legal brief is available to interested Society members; several have been mailed to physicians and other interested individuals. The paper deals with six broad areas of concern to physicians: Basic Legal Principles, Policy Guidelines in General, Guidelines for Specific Hospital/Physician Relations, Corporate Practice Rule, Medical Staff Membership and Privileges, Relationships Between Medical Staff and Hospital Governing Boards.

The Committee is aware of legislation before the 1976 Iowa General Assembly which would require professional and occupational licensees "to participate in continuing education as a condition of license renewal." The IMS position, as established by the House of Delegates, is one of basic support for legislation that is permissive in nature, with authority granted to the Board of Medical Examiners (and other Boards) to establish specific CME requirements by rule and regulation. The IMS has maintained close contact with the Board of Medical Examiners on this legislation, and will continue to do so.

Late in January, the chairman of the Committee attended a meeting involving officials of the IMS and the University of Iowa College of Medicine. Actions of the College of Medicine to enhance communications and understanding between staff physicians at University Hospitals and physicians in private practice were outlined. A report will be presented to the House of Delegates in May by John Eckstein, M.D., Dean.

The IMS was represented at the 1976 AMA Congress on Medical Education in Chicago January 30-February 1. Discussion sessions focused on maintaining professional competence, government involvement in medical education, accreditation, recertification and relicensure.

The Committee wishes to call attention to the IMS Scientific Program in Iowa City, April 6-8. It includes a wide range of scientific discussions, and is approved for 14 hours of prescribed credit by the American Academy of Family Physicians and Category I Credit/AMA Physicians' Recognition Award.

CARL R. ASCHOFF, M.D., *Chairman*

COMMITTEE ON MEDICAL SERVICE

The Committee has submitted two specific recommendations to the Executive Council since the 1975 House of Delegates and has dealt with several other topics on an advisory or informational basis.

Equity Fee Adjustment—The Executive Council approved a Blue Shield program which allows an upward fee adjustment for physicians whose malpractice premiums have increased sufficiently to meet established criteria approved by the State Insurance Commissioner. According to Blue Shield, 153 physicians have applied for the program and 69 have qualified.

Surgical Treatment of Obesity—Following a detailed review of the IMS guidelines established by a special subcommittee, the Executive Council reaffirmed its action of October, 1974. The guidelines are:

1. A complete psychiatric evaluation and consultation to determine patient motivation and intellectual capacity for success in long-term follow-up.

2. A complete medical workup, consultation, and evaluation of the need for surgery.

3. The patient should be at least 25 years of age with the exception of those who have compelling complications of obesity such as skeletal problems, severe heart conditions or diabetes. In cases where obesity surgery (jejunoileostomy) is deemed necessary, the procedure, felt currently to be purely experimental, should be done only in a university medical center until such time as long-term follow-up reports are available.

4. Patient's weight should be at least two times the ideal weight according to the mean weight of the medium frame on the Metropolitan weight scale. The patient should have been at this weight for at least five years and refractory to medical therapy for at least three years.

In its continuing evaluation of this matter, the Committee has asked all Iowa hospital medical staffs to submit information on all cases done so far in Iowa and to ascertain up-to-date mortality and morbidity figures. Each medical staff has been requested to transmit any experience with the procedure including any post-surgical complications and subsequent hospitalizations, when applicable.

Several additional matters are under continuing review, including (1) the use of CPT coding for reporting to third parties (Blue Shield indicates that 55 per cent of claims received are precoded using CPT codes); (2) the manner in which UCR fees are determined and the maintenance of fee profiles; (3) the activities of the Iowa Foundation for Medical Care (the Committee also serves as a committee for IFMC); (4) the ongoing service as an appeal body for peer review cases.

The House is reminded the Committee on Medical Service includes members recommended by the various specialty organizations. Thus, the Committee serves as an important communications link between the specialty groups and the Iowa Medical Society.

R. S. GERARD, M.D., *Chairman*

SUBCOMMITTEE ON MEDICAL PRACTICE IN HEALTH FACILITIES AND HOMES

Information on Iowa nursing and custodial homes is available in the file of the Committee for reference use. As of December 31, 1975, there were 393 nursing homes in Iowa with 25,348 beds. Of these, nearly 12,000 are occupied by Medicaid recipients. Just over 51% of the Medicaid budget is expended to provide for these persons.

The State of Iowa is now implementing a new law (which became effective January 1, 1976) which reclassifies nursing and boarding facilities into three categories; previously there were seven. The new classifications are skilled nursing, intermediate care, and residential. The rules and regulations covering these new categories are being developed by the Department of Health.

Informal liaison has been maintained with the Health Facilities Association of Iowa. The HFAI is a non-profit body with a membership of 225 proprietary and nonproprietary licensed long term health care facilities representing in excess of 16,300 beds. The Committee has volunteered to provide medical counsel to the HFAI; this counsel has been offered in connection with the proposed development of a peer review program by the HFAI.

The House is reminded of the six points contained in a statement approved by the IMS Executive Council in 1974. These called for the IMS to support (1) construction of more nursing and custodial homes, particularly in shortage areas; (2) realistic reimbursement schedules so satisfactory living conditions can be provided; (3) prudent use of health care personnel, balancing availability of funds with the need for adequate services; (4) efforts to combine required inspections to foster governmental economy and reduce the time needed for this activity; (5) cooperation with state agencies to increase physician understanding of nursing and custodial home programs in Iowa; and (6) physician follow-up on nursing home orders to see they have been implemented.

In the area of home care, the State of Iowa has added three county public health nursing services this year, bringing the total to 93. There are 180 public health nurses in full or part-time capacities with an equal number serving in the 16 Visiting Nurse Associations. The number of Medicare-certified home health agencies has increased from 60 to 68. Services to all ages by county public health nurses increased from 106,000 in 1974 to 122,000 in 1975.

J. F. VEVERKA, M.D., *Chairman*

MEDICO-LEGAL COMMITTEE

Professional liability has been the single subject before the Medico-Legal Committee this year. Organizationally, to allow for appropriate attention to this important matter, a Professional Liability Executive Committee was formed in 1975. This Committee consists of three persons from the Medico-Legal Committee, three from the Legislative Committee, and one from the Board of Trustees.

At the outset, please be aware that a supplemental re-

port will be prepared just prior to the convening of the House of Delegates to provide an assessment of the situation as it exists at that time.

As of now, it is possible to report the Iowa professional liability picture is relatively stable. This statement may seem ludicrous to those physicians who have experienced or who are experiencing costly renewal or even non-renewal problems. But, in general, considering the entire Iowa doctor population, and based essentially on the number and nature of reports made to the Iowa Medical Society, no significant further deterioration of the market has occurred. The high risk classifications, particularly anesthesiology, have the most severe problems. It is for these physicians we need to be most concerned and active.

COVERAGE AVAILABILITY

Medical Protective—MP has had difficulty with re-insurance and in most states has had to reduce limits to $100,000/$300,000. In Iowa MP has determined it will maintain its coverage at $200,000/$600,000, presumably for at least 12 months. The Company's reduction from $1 million coverage has created difficulties for those physicians who desire excess coverage which is either unavailable or exorbitant in cost.

St. Paul—The St. Paul announced a broadened marketing policy for Iowa on January 28. Company officials have advised SP will write $100,000/$300,000 basic limits coverage and $1 million excess coverage for all acceptable applicants. This coverage is of the claims-made type which SP has been offering the past year or so.

Aetna—Aetna has remained in the Iowa market with the traditional occurrence type coverage. It wrote 62 new medical malpractice policies in 1975 and in total covers approximately 300 Iowa physicians. The company will write new physicians joining Aetna groups. The company has advised it will withdraw from the state should the Joint Underwriting Association be activated. It has also announced plans to withdraw from all "unit" sales in the future with the intention of becoming involved exclusively in group programs.

There is limited additional marketing activity in Iowa. Professional Mutual of Kansas City is accepting applications. Also, the American Group Practice Association has accepted one or more Iowa clinics into its coverage program.

In summary, the following statements appear to characterize the Iowa insurance availability situation at the moment:

1) Basic limits coverage is fairly accessible at rates which are financially supportable.

2) Excess or umbrella coverage is most uncertain. The tightness and cost of this coverage has caused some physicians to cancel their policies. This is an action which cannot necessarily be advocated but the Iowa experience can offer reasonable peace of mind to those who elect this course.

STATUS OF LEGISLATION

The following summary points are submitted in this area:

1) House File 803 was passed in 1975. It is at least partially responsible for the presence of the market today. A summary of the H.F. 803 was presented in the December, 1975, issue of the IMS JOURNAL.

2) The Legislative Interim Study Committee was formed in late summer and met frequently between August and January. The Society was represented at each of these sessions and presented comments and recommendations. The final report of the Study Committee was submitted to the full General Assembly on January 14. Its contents and recommendations are now being considered, principally by the Commerce Committees in both the House and Senate.

3) The legislative recommendations submitted to the Interim Study Committee by the IMS included (a) a proposal to increase the resources of the Board of Medical Examiners to permit expanded review and investigative activity as a further means of assuring physician competence, (b) an amendment of the Iowa Code to allow for arbitration of future disputes to make possible an experiment in this area, (c) a proposed requirement that any plaintiff be required to provide the defendant and the insurer a 60- or 90-day notice of intent to sue, (d) a provision to permit a form of periodic payments to a plaintiff in lieu of a lump sum award, (e) a limitation on damages for non-economic loss set at $100,000, (f) a limitation on expert witnesses as to specialty and residence, and (g) a state fund supported by all Iowa physicians to finance any and all excess awards.

4) As this is prepared, some of the above recommendations, as well as several proposed by the Interim Committee, are in bill form. It appears likely these several measures will be brought together into a single bill. It is hoped such a bill may gain the support of the committees and eventually a majority of both chambers. The Society is attempting to encourage this course of action.

JOINT UNDERWRITING ASSOCIATION

A hearing on the activation of the JUA was held by the Insurance Commissioner on January 28, 1975. Testimony was presented by several physicians experiencing difficulty in obtaining acceptable coverage. Commissioner Huff has subsequently ruled against activating the JUA at this time. The JUA Board of Directors, on which the IMS is represented, has organized itself this year in the event it is pressed into service.

ARBITRATION PROJECT

The IMS has been in regular contact with the Iowa Hospital Association on the possibility of undertaking a voluntary arbitration project. A change in the law will be necessary to allow this to occur. Discussion of the concept with the Iowa State Bar Association has produced a negative reaction. A day-long seminar on the subject was held in November under joint IMS-IHA auspices.

EXCESS COVERAGE

Considerable time and effort has been given to the investigation of a state excess liability fund (called the Iowa Patient/Physician Protection Fund). IMS representatives have met with AMA actuarial consultants, insurance company officials, the State Insurance Commissioner and others. This program would require participation by all physicians and would necessitate payment into the fund of a set percentage of the basic coverage premium. While the concept is still among the options to be considered, it has not engendered the broad physician support needed to make it a pressing option.

COLLECTION OF DATA

Efforts in this area are badly needed and are now in process. The first edition of a closed-claim analysis undertaken by the National Association of Insurance Commissioners is out and in the hands of the Society. These findings are still too sketchy to form conclusions but the preliminary information suggests the ultimate data will be useful in identifying problem areas and possible solutions.

As stated at the outset, the House of Delegates will be provided an updated report based on conditions as of mid to late April. This report should not be concluded without acknowledging the involvement of many Iowa physicians, particularly active has been Donald Sweem, M.D., as a representative of the Iowa Society of Anesthesiologists.

CLARENCE H. DENSER, JR., M.D., *Chairman*

COMMITTEE ON PUBLIC RELATIONS

Although the IMS is not engaged in a structured "public relations" campaign or program at the present time, the Committee can point to the activities of numerous committees of the Society which have a positive impact on the public, and which are helpful in gaining public understanding and support of medicine's position on various health issues and problems; for example, the great amount of press coverage dealing with the professional liability situation in Iowa; continuing medical education projects; liaison with various departments of state government and voluntary health agencies, etc.

The Committee continues to oversee specific P/R projects which have been successfully implemented by the Society for many years, including the following:

IN THE PUBLIC INTEREST—The "In the Public Interest" section of the IMS JOURNAL is mailed regularly to all newspapers in the state, resulting in follow-up news stories and direct reprints. Subjects discussed this past year included: PSRO, health planning, professional liability, hospital/medical staff relations, pursuit of quality medical care, and others.

AMERICAN MEDICAL NEWS—Sufficient issues of American Medical News are provided to the IMS for distribution each week to all members of the Iowa Legislature.

CONTACTS WITH RADIO AND TELEVISION STATIONS—The IMS cooperates with radio and television stations in securing physicians to participate in programs dealing with health and medical socio-economic subjects. Most of the requests come from stations in the Des Moines and Ames area.

HAWKEYE SCIENCE FAIR—The 18th Hawkeye Science Fair will be April 2 and 3 at the Veterans Memorial Auditorium in Des Moines. This popular event draws over 700 exhibits each year, and an estimated audience of 10,000 persons. The Fair is sponsored by the IMS, the Scanlon Medical Foundation/IMS, Drake University, and the DES MOINES REGISTER AND TRIBUNE.

RELATIONS WITH THE MEDIA—IMS staff members maintain good working relationships with representatives of the mass communications media, including the DES MOINES REGISTER AND TRIBUNE and the wire services, in an attempt to provide them with accurate background for various stories dealing with health programs and issues.

Although projects of the various IMS committees serve to enhance public awareness and knowledge of what organized medicine is and what it does, the Committee wishes to remind physicians that their individual efforts —both in providing high quality medical care to their patients and in assuming civic leadership and responsibilities—constitute the best "P/R" program for the medical profession.

JOHN G. THOMSEN, M.D., *Chairman*

SUBCOMMITTEE ON INTERPROFESSIONAL ACTIVITIES

The Committee on Interprofessional Activities met twice during the past year with representatives of the Iowa Pharmaceutical Association to review and develop appropriate revisions to the "Physician/Pharmacist Code of Understanding."

The Code was originally prepared and approved by the IMS and IPhA in 1959, and amended in 1963. As reported to the House of Delegates last year, the Committee felt there was a need to revitalize the Code and to remind physicians and pharmacists of its existence.

After careful study of the existing Code, representatives of the two professions developed a revision, which was subsequently approved by the IPhA House of Delegates (September 7, 1975) and the IMS Executive Council (October 22, 1975).

The Code was reprinted in the IMS JOURNAL in December 1975. It was prepared in folder form and mailed in February to members of the IMS and IPhA.

The Committee chairman is one of three IMS representatives serving on the Board of Directors of the Iowa Health Council. The others are Donald C. Young, M.D., Des Moines, and Eldon Huston, Executive Vice President. Mr. Huston was elected Secretary-Treasurer of the IHC last fall. The Council is comprised of the associations representing dentists, hospitals, MD's and DO's, nurses, pharmacists, nursing homes, podiatrists, and veterinarians.

The IHC sponsors two main functions each year. One is an educational conference for leaders of the member organizations. This year's program included presentations on PSRO, professional liability problems, health planning activities, Medicaid, and legislative concerns.

The other IHC event is a dinner to recognize the members of the Iowa General Assembly and other state officials. This year's affair was January 27 at the Des Moines Golf and Country Club. Approximately 150 guests and IHC representatives attended. A brief program was presented at the dinner with emphasis placed on the fact that the Iowa Health Council represents approximately 20,000 persons engaged in health care delivery.

IMS staff and office facilities are utilized to coordinate and implement various projects of the Health Council.

C. E. RADCLIFFE, M.D., *Chairman*

COMMITTEE ON SCIENTIFIC WORK

The Program Committee is commended for the excellent program which has been arranged for the 1976 Annual Scientific Session of the Iowa Medical Society. The session will be in Iowa City on April 6, 7, and 8. The facilities of The Highlander Inn and University Hospitals will be utilized.

The program has been approved for 14 hours of prescribed credit by the American Academy of Family Physicians, and Category I Credit/AMA Physicians' Recognition Award.

Full details of the program will be published in the March issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY.

V. L. SCHLASER, M.D., *Chairman*

COMMITTEE ON STATE DEPARTMENTS

A Committee on State Departments is provided for in the governing language of the Iowa Medical Society. This Committee's assigned role is that of participation in a broad range of human activities, each of which has an impact on the health and well being of society. Actual work of the Committee on State Departments is done by its six subcommittees. These subcommittees are Aging and Chronic Illness, Maternal and Child Health, Psychiatric Care, Public Assistance, Rehabilitation, and Safe Transportation.

The chairmen of the several subcommittees comprise the Committee on State Departments. In addition to providing a liaison relationship between the profession and various departments and agencies of state government (through the subcommittees), the parent Committee on State Departments attempts to foster broad cooperation with the State Department of Health. In this connection, it is a pleasure to recognize the several Iowa physicians who have served on the State Board of Health for several years: E. E. Gamet, M.D., Lamoni; P. J. Leehey, M.D., Independence; and P. M. Seebohm, M.D., Iowa City. Norman L. Pawlewski is now in his third year as Iowa Commissioner of Health.

Matters pertaining to public health are published each month in the JOURNAL OF THE IOWA MEDICAL SOCIETY. Through this and various other communication mechanisms, we are pleased that 1975-76 has seen a continuation of the good rapport which has existed for a number of years with the State Department of Health.

E. E. LINDER, M.D., *Chairman*

SUBCOMMITTEE ON AGING AND CHRONIC ILLNESS

Problems associated with the funding of the Iowa Medicaid Program have been prominent in the news in recent weeks. It is well known that a major portion of the Medicaid budget is disbursed to care for residents of Intermediate Care Facilities. Through the first 11 months of 1975, 51.88% of the Medicaid expenditures were paid to ICF's.

A proposed cutback in the Medicaid program was averted in January when the General Assembly appropriated $13.8 million in supplemental money to provide necessary funds for the balance of the fiscal year. The Assembly is considering a $30,000 study of the Medicaid program to determine where inefficiencies exist and where savings can be achieved.

In the area of care for the aged and chronically ill, the State of Iowa is phasing in a new law which reduces from seven to three the number of facility classifications. Under the law, which became effective January 1, 1976, the facility designations are skilled nursing, intermediate care and residential. The intermediate care includes basic and intermediate nursing homes.

As of December 31, 1975, there were 393 licensed nursing homes in Iowa with 25,348 beds. There have been 21 homes (549 beds) closed since July. Conversely, there is a reasonable amount of new construction in process.

The Iowa Commission on Aging has existed in a new form since 1973 with nine persons serving on it. Woodrow Morris, Ph.D., Iowa City, serves as the chairman. There are 11 regional agencies on aging which have been formed about the state in the past 18 months.

E. E. LINDER, M.D., *Chairman*

SUBCOMMITTEE ON MATERNAL AND CHILD HEALTH

A meeting of the Subcommittee on Maternal and Child Health is scheduled as this report is prepared. The meeting will be for the principal purpose of considering the position of the Iowa Medical Society with respect to making immunization a compulsory proposition. This subject has been discussed by the Subcommittee on a number of occasions through the years. Its consideration at this time is prompted by the introduction of legislation (House File 1143) which provides (with certain exceptions) that persons shall be immunized against diphtheria, pertussis, rubeola, rubella, tetanus and poliomyelitis before school entry.

In its discussions of this subject, the Subcommittee on Maternal and Child Health has evaluated data from a variety of sources, including the U. S. Center for Disease Control. These discussions have most always been together with personnel from the Department of Health. There has been a standing invitation with the Department to submit information which demonstrates the success of compulsory programs. While the material reviewed by the Subcommittee has not shown a significant difference in immunization levels between the compulsory and voluntary states, it is acknowledged that some changes may have occurred since the subject was looked at in depth several years ago.

The current policy of the Iowa Medical Society on this aspect of immunization administration was set by the House of Delegates in 1973 with the approval of the following language: "Resolved, That the Iowa Medical Society encourage and support immunization for all children on a voluntary basis."

Until this policy is changed by either the House of Delegates or the Executive Council, it is not possible for the Society to support legislation such as that now introduced. The Committee is expected to consider the subject at its March meeting and may submit a recommendation to either the Council or House. Timing is a problem inasmuch as the bill now in the Assembly may be acted upon before any policy change can be considered.

In the interest of continually reviewing this immunization policy, representatives of the Subcommittee participated in a December 10 seminar on the concept of compulsory legislation. This seminar was held under the auspices of the Iowa Immunization Advisory Committee. Those advocates of state legislation who participated in the seminar were expecting a more deliberate consideration of the matter with a legislative proposal to be in bill form in 1977. This timetable was shoved forward by several interested legislators.

The House of Delegates is reminded that it approved a policy statement in 1974 which had as its theme, "First State to Eradicate." This statement was developed on a cooperative basis by the Iowa State Department of Health and the Subcommittee on Maternal and Child Health. Contained in this statement are references to statistics and demographic characteristics which support a contention that communicable disease eradication is a worthy and attainable goal. In subsequent pursuit of this goal, the Society has (1) distributed several informational mailings to physicians, (2) encouraged designation of a physician immunization chairman by each county medical society, and (3) co-sponsored with the Department of Health a special seminar at IMS Headquarters on May 29, 1975.

In other matters, the Committee (1) involved itself in the 1975 Immunization Action Month (October), (2) conferred with T. D. Scurletis, M.D., new director of the Maternal and Child Health Division of the State Department of Health, and (3) continued its involvement in the activities of the Maternal Mortality Committee.

GEORGE L. BAKER, M.D., *Chairman*

SUBCOMMITTEE ON PSYCHIATRIC CARE

The Subcommittee on Psychiatric Care has met on four occasions this year and has another meeting scheduled as this report is prepared. Various topics have been considered in the course of these meetings.

Several legislative measures pertaining to mental health are now before the Iowa General Assembly. These have

been reviewed by the Subcommittee. The following explanatory comments are offered:

Establishment of a State Department of Mental Health Services. A document known as Draft Bill VI has been developed by the Mental Health Subcommittee of the Social Services and Mental Health Subcommittee of the General Assembly. This extensive proposal would incorporate the Mental Health Authority and the mental health components of the Department of Social Services into a new State Department of Mental Health Services. The bill prescribes the powers and duties of the new department and sets up a seven-member mental health commission. The Subcommittee on Psychiatric Care has recommended the Society oppose this legislation and is requesting an opportunity to offer its reasons at the April meeting of the Executive Council.

Mental Health Authority. Another bill in draft form contemplates establishing the Mental Health Authority as an independent agency of State Government. Transferred to it would be jurisdiction over the State Mental Hospitals which are now under the authority of the Department of Social Services. The Subcommittee, in line with the previously noted opposition, believes this legislation is unwise.

Transforming the Mount Pleasant Mental Health Institute Into a Correctional Facility. This bill (H.F. 1152) proposes to change the Mount Pleasant MHI into a correctional facility to meet the increasing state needs for penal space. The Subcommittee has reaffirmed a previous position on this subject, i.e., until more conclusive data becomes available to justify any change, the state's four MHI's should be continued in operation. The factor of patient proximity to home and relatives was cited as being important.

Licensing of Social Workers. This self-explanatory title (H.F. 1157) is recognized as being likely to pass in this session. The Society's historic position has been one of opposition to this type of licensure.

The Subcommittee has continued its dialogue with representatives of Blue Cross/Blue Shield on ways of restructuring the benefits for mental health care to make them more effective and economical. The Subcommittee is persuaded that increased provision for outpatient coverage would be desirable. The Subcommittee has expressed criticism over the provision in the major medical realm which differentiates between payment levels for medical treatment (80%) and psychiatric treatment (50%). While the discussions with BC/BS representatives has resulted in only limited progress, it is anticipated they will be continued.

The new Iowa commitment law which became effective in 1975 has been considered at length. The law has many uncertain and complex features which physicians will find difficult and frustrating to follow. A summary article on the new law was prepared by S. M. Korson, M.D., a member of the Subcommittee, and presented in the November issue of the IMS JOURNAL.

Members of the Subcommittee have been occupied with various state activities related to mental health planning. This is an ongoing activity and is currently involving the distribution of a questionnaire to private psychiatrists to seek data on treatment being provided in this sector. The Subcommittee is cognizant of the eventual merging of all health planning activity into the new HSA program.

The Subcommittee has reviewed independently the booklet of the American Medical Association which is entitled, "The Impaired Physician." The Subcommittee is on record as being available to consult with individual physicians on matters in this area.

HERBERT L. NELSON, M.D., *Chairman*

SUBCOMMITTEE ON PUBLIC ASSISTANCE

The interest of the Subcommittee has been directed entirely to problems associated with the Iowa Medicaid Program. Late in 1975 the State Department of Social Services announced Title XIX funds would be insufficient to cover the existing program for the balance of the fiscal year. It was revealed that either services would have to be curtailed, fees would have to be reduced, or additional funds would have to be provided.

The Society has been involved extensively in deliberations on this matter. Representatives have met with legislators, with members of the Governor's staff, with the Medical Assistance Advisory Council and others. In these discussions the IMS has opposed any curtailment in fees.

These excerpts from a letter filed with the chairman of the Committee on Human Resources of the Iowa House of Representatives offer a perspective on the Society's attitude regarding current developments in the Medicaid program:

"You may recall the medical profession participated actively in the development of Title XIX enabling legislation back in 1966. In the intervening decade, Iowa physicians have been principal providers of service to Medicaid recipients. . . .

"Those Iowa physicians who provide services to Medicaid beneficiaries do so knowing and believing that these individuals, many of whom are in the older age bracket, need and deserve quality care to the same degree as any patient. This care has been delivered by many physicians in a humanity-serving or philanthropic sense. To clarify this statement, physicians are reimbursed by Medicaid on the basis of a federal formula which is built on charges made in calendar year 1971. Fees paid to physicians are limited to a 17.9% increase over 1971 charges. With these reimbursement provisions in effect, and with the inflationary conditions which have prevailed, particularly with such overhead costs as professional liability insurance, you can recognize the delivery of care to Medicaid patients is a contributory proposition. It is estimated that the present Medicaid fee allowance to physicians on a statewide basis represents perhaps 60 to 70% of the present charge for the service. Further curtailments threaten the active participation of many physicians. . . .

"It is additionally significant to note the rather reasonable annual level of payment to medical doctors for care of Medicaid patients. For the last complete fiscal year, it has been reported that the average annual payment per individual doctor was $2,400. Through the 10-year program, the portion of the Medicaid dollar going for physicians' services has hovered around the 10% level. In the first 10 months of 1975, for example, 10.67% of the Medicaid expenditures were for the services of medical and osteopathic physicians. . . .

"The current budget deficit is the result of various factors over which the physicians and other providers have little or no control. For example, the determination of who is eligible for Medicaid is and should be a governmental activity. In this connection, the decline in the economy and other factors have caused a significant increase in the Medicaid patient load. It has increased from 122,000 in 1974 to 137,322 in 1975. This boost in number of participants has had an obvious and definite impact on the current appropriation which was approved. . . .

"The IMS recognizes the need for continuous appraisal of utilization practices under a program such as Medicaid. There are perhaps instances where recipients are receiving benefits for care, either of limited necessity or at a level beyond what is needed. Those involved with the program must make the effort on an ongoing basis (1) to

curtail any abuse, be it patient or physician, and (2) to assure quality control among the providers. In the latter area, the peer review activity of the medical profession in Iowa has served both private and public medical care programs exceedingly well. . . .

"We are fully cognizant of the announced intention of the Department of Social Services to limit Medicaid reimbursement for hospitalization to seven days and to impose certain additional cost-saving measures. We hope such a drastic step can be avoided in view of the important health services which are rendered to many Iowans through the Medicaid program. We believe maximum consideration should be given by members of the Assembly to allocating funds which will allow the program to serve as it has."

We are pleased to advise the Assembly has approved a supplemental appropriation of $13.8 million which is sufficient to maintain the program through the current fiscal year. In making this allocation, the lawmakers indicated a need to evaluate the program to find and correct weaknesses and abuses. An appropriation of $70,000 has been proposed to accomplish this.

The Society and the Subcommittee will continue to follow the developments in this important area.

A. J. HAVLIK, M.D., *Chairman*

SUBCOMMITTEE ON REHABILITATION

The Subcommittee on Rehabilitation continues as part of the Society's organizational structure. However, there has been no occasion to hold a meeting this year.

It is possible to report that the federal Supplemental Security Income program has progressed satisfactorily since its beginning in 1974. It replaced the former federal-state programs of public assistance payments to the aged, disabled and blind.

Iowa physicians have a significant role to play in this program from the standpoint of providing medical evidence in instances where disability is claimed. It is estimated there will be 24,500 Iowa applicants for SSI benefits in fiscal 1976 and approximately 53% of these will be approved.

The new federal privacy act has had some impact on the SSI program. Its significance was discussed in a letter from the state agency handling the Social Security Disability Program to Iowa physicians late in 1975. This act permits claimants to obtain and review personally their medical reports. This new procedure has reportedly caused some physicians to elect not to do the examinations. The state agency has explained the report is sent first to the claimant's treating physician for review. Then if that review is not acceptable to the claimant, his attorney may examine the report, and finally the claimant himself is afforded opportunity to review the findings. A copy of the explanatory letter is on file at IMS Headquarters.

Iowa physicians who do perform these examinations are encouraged to provide objective clinical findings in their initial reports. A general statement that disability exists is not adequate and necessitates follow-up correspondence. This can be avoided by the initial provision of objective evidence, including laboratory findings.

The Social Security Program encourages persons to return to gainful employment whenever possible. At the time a person's disability is processed, he is considered for Vocational Rehabilitation Services. Referral to rehabilitation services is made as often as possible. Many disabled persons have found it possible to return to work with rehabilitation assistance.

Acknowledgement is again made of the service rendered by Homer E. Wichern, M.D., Des Moines, as chief medical consultant, Rehabilitation Education and Services Branch, Iowa Disability Determination Unit, Social Security Disability Program.

C. B. LARSON, M.D., *Chairman*

SUBCOMMITTEE ON SAFE TRANSPORTATION

In mid-January, the Committee on Safe Transportation met with officials of the Iowa State Department of Transportation. The functions of the new Department of Transportation were outlined, and it was acknowledged that, in accordance with the new organizational structure of the department, the IMS Medical Advisory Board will serve the DOT, rather than the Department of Public Safety, as it has in the past.

DOT officials expressed their desire to continue to work closely with the Safe Transportation Committee and the Medical Advisory Board on matters of mutual interest and concern; further, the Committee was encouraged to offer constructive suggestions to the DOT at any time.

In specific reference to the Medical Advisory Board, there was concurrence that the anonymity of its members be maintained in order to assure its continued effective service. The function of the Advisory Board is to review and make recommendations on certain medical case files of drivers license applicants referred to it by the DOT.

The Safe Transportation Committee and DOT officials reviewed and expressed support for a bill which would authorize a licensed driver to note on his license that he is an organ donor. It was noted that enactment of such legislation would not authorize the removal of an organ but would alert those at the scene, and the attending physician, that the individual is a potential donor, as provided for under the Uniform Anatomical Gift Act. The proposed bill also has the approval of the IMS Committee on Organ Transplantation and the Kidney Foundation of Iowa.

ARTHUR H. DOWNING, M.D., *Chairman*

PUBLICATIONS COMMITTEE

The JOURNAL OF THE IOWA MEDICAL SOCIETY is published 12 times each year in an effort to bring member physicians interesting and useful scientific and socio-economic information. The JOURNAL is designated as the official publication of the Society and in that sense exists as the document Iowa historians will look to as a reflection of the medical profession at the time of the bicentennial.

The historical or reference aspects of the JOURNAL are represented, for instance, by the July issue in which the proceedings of the House of Delegates are published. An accounting of medical education in Iowa is made each year in the April University issue.

The U. of I. College of Medicine continues to be a major source of the scientific material which is published in the JOURNAL. We are grateful to the various faculty authors who see fit to submit their writings. We are indebted to Richard M. Caplan, M.D., associate dean for continuing medical education, for his efforts to stimulate and recruit manuscripts for the JOURNAL.

At the same time, we have been gratified by the increased submission of articles by Iowa physicians who are in private practice. The number of papers coming from this sector has gone up and we are pleased by this.

It is our custom in concluding these reports to encourage member physicians to forward editorial ideas, case reports, scientific manuscripts and news items. We assure you we will give them every consideration.

MARION E. ALBERTS, M.D., *Scientific Editor*

Reports of Special Committees

COMMITTEE ON ALCOHOLISM

The Committee on Alcoholism has met three times during the 1975-76 Society year. The following subjects have been considered during the year:

1. The State Alcoholism Program. In its first operative year since legislative enactment in 1974, this new program has caused some uncertainty and confusion. The basic intent of the program, i.e., to remove the alcoholic from the penal setting and place him in the health care sector, is supported by the IMS Committee. Differences of thinking have emerged this year with respect to the manner in which the state is reimbursing local alcoholism programs for services rendered. The Committee has met with Jeff Voskans or his staff on several occasions this year to receive information on the status of the total program. Questions have been raised on the signing of forms, the handling of transients, etc.

A request has been made of the Committee by the Iowa Division on Alcoholism that it develop a set of guidelines or general orders to cover detoxification. It is believed such guidelines will be valuable to the Division for its distribution to various alcohol service centers and individual physicians. An alcohol treatment protocol was developed by the Committee several years ago and published in the IMS JOURNAL. A summary of this material is being assembled by the Committee for use by the Division in pamphlet or other form. The Committee has requested the Division to prepare brief written guidelines to help providers better understand the administrative procedures to be followed when services are rendered under the state alcoholism program.

In terms of 1976-77 appropriations for the alcoholism program, the Committee has been advised that funding will be the same or slightly more than it is currently. In addition to the nine-member Iowa Commission on Alcoholism, which was formed in 1974, there has recently been named a Citizens Advisory Council on Alcoholism. F. William Bennett, M.D., a member of the IMS Committee on Alcoholism, has been named to this 15-member unit.

2. The Committee is cooperating in a current research project which is seeking to update the Mulford Alcohol Studies made in 1963. This research effort is intended to assess the attitude and practice of Iowa physicians in handling alcoholic patients. The current study is being undertaken by Mr. Harold Bischoff, a graduate student at the University of Iowa. The Committee's involvement to date has been that of providing a letter of support to accompany the survey questionnaire which Mr. Bishoff has distributed to a selected sample of Iowa physicians.

3. The Committee, principally through the efforts of its chairman, cooperated in the presentation of five alcoholism seminars for physicians and others in November and December. Attendance was less than had been hoped and totalled just under 100.

4. The Committee has met with representatives of several alcohol programs (Jasper and Pottawattamie counties) in the state to hear of problems and to make suggestions as to their solution. These discussions appear to have been useful and will be continued as possible.

5. The Committee has had additional involvement in educational programs. It continued to encourage youth participation in the Northwest Iowa Summer Workshop which was held this year in Estherville; several members of the Committee participated as faculty members. Further, the Committee, through its member, Harold Moessner, M.D., was involved in The Conference on Medical and Nursing Management of the Alcoholic Patient held at the University of Iowa, November 19 and 20.

The Committee is pleased to devote a modest amount of time to this important problem. Questions, suggestions and criticisms from member physicians regarding medical involvement in alcohol treatment are welcomed.

S. M. HAUGLAND, M.D., *Chairman*

COMMITTEE ON ALTERNATE DELIVERY SYSTEMS

The Committee has continued to function in an advisory capacity to individuals and organizations interested in alternate delivery systems programs.

The Committee met with physicians representing the Rural Health Services, Inc., program in Davis County. During this meeting, the Committee reviewed guidelines for defining what should be considered an "established patient" for purposes of eligibility to enroll in the program and offered guidance and advice on the literature and methods of implementing the enrollment program.

Blue Cross and Blue Shield serve as administrators for the program and have submitted the following status report:

"Blue Cross and Blue Shield of Iowa were encouraged by the State Medical Society to assist interested providers in the development of alternate delivery systems. The ADS Committee of the Society was, in part, developed to review these programs and report their activity to the Society. The Boards of Blue Cross and Blue Shield have gone on record supporting this endeavor by providing staff assistance to interested provider groups to develop ADS programs which are cost effective and quality assured. With guidance from the Alternate Delivery Systems Committee of the Medical Society, RHS was developed and began operation November 1, 1975. The program provides for a broad comprehensive set of benefits to residents of Davis County, Iowa and established patients of record who reside outside the county. To date, there are approximately 4,000 people enrolled in Rural Health Services. Because of the relatively short time since the start of the program, statistical data is not available for review."

The Committee stands ready to offer its advice and counsel when requested, as suggested by the House of Delegates.

J. F. BISHOP, M.D., *Chairman*

COMMITTEE ON ARCHITECTURAL EDUCATION

The Committee on Architectural Education has not had occasion to meet during the past year. Because of other priority projects, the final preparation and printing of a set of guidelines and procedures for use by individuals involved in hospital/health facility building programs has been delayed.

The Committee stands ready to meet with representatives of the Iowa Chapter/American Institute of Architecture to discuss matters related to the health facility design and construction.

WILLIAM R. BLISS, M.D., *Chairman*

COMMITTEE ON BLOOD BANKING

Members of the IMS Committee on Blood Banking have been actively involved in the organization and activities of the Iowa Blood Council, which was legally incorporated in June 1974. Your Committee chairman is presently serving as Vice President of the Blood Council. In addition to the IMS, membership in the Council includes representatives of the Iowa Association of Blood Banks, Iowa Association of Pathologists, Iowa Hospital Association, Department of Health, Red Cross, Iowa Society of Medical Technologists, Iowa Society of Osteopathic Physicians and Surgeons, plus individuals from Iowa health insurance carriers, press and newspapers, organized labor, and consumers.

The IBC is a voluntary organization which exists to coordinate the efforts of existing blood banks and hospitals in supplying an adequate amount of safe blood to the citizens of Iowa. In order to accomplish this goal, the Council will assist in the formation of regional blood supply programs.

The Council is also involved in the development of a Directory of Blood Services in Iowa, and a public information campaign to generate public awareness of and a positive response to the continuing need for blood. The Scanlon Medical Foundation/Iowa Medical Society has contributed $200 to assist the IBC in carrying out its programs.

The Blood Banking Committee is also being kept apprised of legislation introduced into the Iowa General Assembly which concerns blood labeling and criteria for donor selection. The members of the Committee have been asked to transmit their comments and concerns about this proposed bill to the Society's Committee on Legislation.

W. S. PHETEPLACE, M.D., *Chairman*

COMMITTEE ON COMMUNITY EMERGENCY MEDICAL SERVICES

Representatives of the Iowa Medical Society remain active in emergency medical service planning at the state level.

William R. Bliss, M.D., Secretary of the IMS, has served as Chairman of the Governor's Emergency Medical Services Advisory Council during the past year, and has been a member of the Council since its inception. Your Committee Chairman represented the Society on the Advisory Council for several years, and the present representative is Michael Abrams, M.D., who is also a member of the Committee.

Under the direction of the EMS Advisory Council, emergency medical service capabilities of Iowa hospitals have been categorized, and an EMS plan has been developed. The plan includes standards for hospital emergency rooms and ambulance services, and also serves as a guide for the development of emergency medical services in the state.

An EMS progress report was published last March in the IMS JOURNAL, and a similar report will be included in a future issue.

In response to a request from the American Medical Association, the IMS will, when called upon, cooperate in arranging and co-sponsoring an EMS Seminar for Iowa physicians. A representative of the AMA is to be in contact with the IMS at some future date to discuss specific details, and the membership will be kept apprised of any developments in this regard.

A. H. DOWNING, M.D., *Chairman*

COMMITTEE ON DELEGATION OF AUTHORITY

The Committee on Delegation of Authority has met three times during the past year with representatives of the Iowa Nurses' Association, Board of Nursing, and Board of Medical Examiners to discuss projects and issues of interest to the medical and nursing professions.

Primary attention has been given to recent trends to expand the role of the nurse in health care, and efforts of the Iowa Nurses' Association to amend the Nurse Practice Act in light of these trends.

Discussion during the three joint meetings centered on the use of the terms "diagnosis and treatment" in the definition of the practice of nursing. IMS representatives have urged the INA to avoid the use of these words, since "diagnosis" is recognized as a medical term and is used to describe the art or act of identifying a disease from its signs and symptoms. As a counter proposal, the INA has inserted the word "nursing" in its definition—i.e., ". . . the practice of the profession of nursing as a registered nurse is defined as nursing diagnosis and treatment of human responses to actual or potential health problems through such services as case finding, referral, health teaching, health counseling and the provision of care supportive to, or restorative of, life and well-being . . . nursing diagnosis means the identification of, and the discriminatory judgment about, physical and psychosocial signs and symptoms essential to determining effective nursing intervention. . . ."

The IMS Committee on Legislation has been kept apprised of developments regarding proposed amendments to the Nurse Practice Act, and is keeping close watch on a bill that was recently introduced in order to assure a clear and precise definition of "nursing diagnosis and treatment."

Representatives of the IMS and INA participated in the 1975 National Conference of the Joint Practice Commission (Medicine/Nursing). Recommendations developed at the conference have been discussed by medicine and nursing representatives at the state level. It should be noted that the IMS Committee meets in joint session with nursing representatives as the "MD/RN Liaison Committee (Iowa Joint Practice Commission)," and this conforms with a recommendation of the National JPC.

In previous years, the IMS, INA, and Board of Nursing have issued the following joint statements: 1) Nursing Functions for Registered Nurses Practicing in Hospitals or Organized Agencies in Iowa; 2) Intravenous Administration of Fluids and Medications by Professional Nurses Practicing in Hospitals or Organized Agencies in Iowa; 3) Ear Piercing. A fourth joint statement dealing with "Standards of Nursing Practice in Hemodialysis Units" has been offered by the IMS. The document is still under study by the INA. The MD/RN Liaison Committee will also begin work on a joint statement concerning the drawing of blood gases by nurses.

The Family Nurse Practitioner Project, sponsored by the IMS and Iowa Hospital Association, with funding from the Iowa Regional Medical Program, was officially completed on September 26, 1975, when six registered nurses graduated from the FNP program at the University of North Dakota School of Medicine.

Each nurse participating in the program was assigned to a physician preceptor in Iowa during the year-long program. Five of the nurses are currently employed by the physicians who served as their preceptors, and the sixth is employed in an established satellite clinic in Granger.

An evaluation of the project will be undertaken in the coming months to determine whether the use of the FNP as a new category of health manpower can help to increase the availability of primary health services in rural Iowa. Both the IMS and the IHA have emphasized that, under the FNP program, the nurse will serve within an organized health system, under the supervision of a physician, and not as an independent practitioner.

Herman Smith, M.D., a member of the Committee, served on the Governor's Commission to Study Nursing in Iowa. The Commission completed its work last June. Its report and recommendations have been published and made available to the Board of Nursing and other interested agencies and individuals, including the IMS. The Board of Nursing has the report under study, and has not, as yet, taken any action in regard to the recommendations.

L. F. STAPLES, M.D., *Chairman*

COMMITTEE ON DELIVERY OF HEALTH SERVICES

Bracketed portion of this report was referred to Reference Committee on Reports of Officers and Miscellaneous Business.

[The Committee on Delivery of Health Services met late in January with officials of Blue Cross/Blue Shield and other interested individuals to discuss matters concerned with the role and utilization of "physician extenders"—i.e., physician's assistants and family nurse practitioners—and problems emanating from a ruling of the Social Security Administration regarding reimbursement for services provided by PA's and FNP's.

Under the SSA ruling, services provided by physician extenders must be furnished under the direct personal supervision of a physician to be considered covered under the Medicare B and Title XIX programs. "Direct personal supervision" means that the supervising physician must be physically located on the premises where the services are being provided; availability by telephone is not considered to constitute direct personal supervision.

As a result of the January meeting:

1. The Committee, acting in an advisory capacity, reacted favorably to proposed Blue Cross/Blue Shield involvement in an experimental program of the Department of Health, Education and Welfare, whereby physicians would be reimbursed for services provided by physician extenders in their employ. BC/BS is seeking designation from HEW as one of the carriers to participate in a pilot program.

2. The Committee recognized problems confronting Blue Cross/Blue Shield in providing reimbursement under BC/BS private contracts for services provided by a physician extender in a location other than the employing physician's office—i.e., payment based on the UCR charge of the physician, or a lesser charge established for the physician extender. However, the Committee referred to an existing AMA guideline regarding this matter, and IMS support of it—i.e., reimbursement on the basis of the physician's usual, customary and reasonable charge. The Committee acknowledged that any change in this position would have to be authorized by the IMS Executive Council or House of Delegates.

3. Even though the Committee is aware the IMS does not have the staff or resources to conduct an in-depth, scientific evaluation study regarding the effectiveness and efficiency of the physician extender, it is recommended that (a) the IMS, through the Committee on Delivery of Health Services, collect and review information on this subject available from various sources in the state—i.e., College of Medicine, Board of Medical Examiners, Blue Cross/Blue Shield/HEW experimental program, physician extenders and their employing physicians; (b) an IMS sponsored conference should be arranged for physician extenders, their employing physicians, and other interested parties to discuss the "pros and cons" of the use and value of physician extenders; and (c) following a review of available data and the results of the proposed conference, the IMS, based on recommendations of the Committee on Delivery of Health Services, should make a formal statement relating to the role and utilization of the physician extender in Iowa.]

These recommendations will be called to the attention of the IMS Executive Council and/or House of Delegates for comment and action.

The Committee has also been kept apprised of developments relating to the creation of a Health Systems Agency in Iowa, as authorized under P.L. 93-641 (National Health Planning and Resources Development Act of 1974). County medical society presidents and secretaries, and officials of the IMS have been provided regular mailings reporting on the progress that has been made in this regard, and a News Bulletin was sent to the membership early in February listing the names of Iowa's newly-formed HSA Board, and the physician members of the five sub-area advisory councils to the HSA. The medical profession should be pleased that it has four knowledgeable representatives serving on the HSA Board—Lawrence Ely, M.D., Des Moines (provider-at-large, nominated by the IMS); Paul Seebohm, M.D., Iowa City (provider-at-large, nominated by the College of Medicine); Russell Gerard, M.D., Waterloo (provider, representing Subarea #1); John Tyrrell, M.D., Manchester (provider, representing Subarea #5). Doctor Tyrrell is also Vice President of the HSA Board.

HSA functions are to: gather and analyze data; establish health systems plans and annual implementation plans; provide technical and/or limited financial assistance to organizations seeking to implement the plans; coordinate activities with PSROs and appropriate planning and regulatory entities; review and approve or disapprove applications for federal funds for health programs within the health service area (1122—certificate-of-need); administer, monitor and evaluate health resources development.

The Department of Health has been designated by the Governor as the State Health Planning and Development Agency. Its major responsibilities are to prepare, review and revise a State Health Plan, based on the health systems plan devised by the HSA; serve as the state's Section 1122 agency; administer the certificate-of-need program once it is approved; make findings as to the need of new institutional health services; determine appropriateness of all institutional health services.

A State Health Coordinating Council will also be appointed, to be composed of at least 16 members appointed by the Governor, with 60% of the members to be representatives of the HSA and at least one-half consumers. The Council will prepare the State Health Plan, review budgets and applications for assistance of the HSA, and advise the state agency on the performance of its functions. It will also review any state plan or application submitted to HEW for receipt of funds under allotments made to the state for health program.

The Committee is well aware of the dangerous ramifications of P.L. 93-641, as well as its ambiguities, but feels it is probably best for the medical profession to attempt to provide leadership and counsel in its implementation, rather than to defer totally to others. It will watch with great interest any attempt by the AMA to challenge the

constitutionality of this federal law in the court, as it has indicated it might do.

The new federal health planning program will eventually replace the existing Comprehensive Health Planning Agency, as well as the planning activities undertaken in the past by the Iowa Regional Medical Program and Hill-Burton program. In reference to the Office for Comprehensive Health Planning, it should be acknowledged that Doctor John Tyrrell is presently serving as chairman of the OCHP Advisory Council, and he also served as chairman of the OCHP Health Manpower Committee. A copy of the Comprehensive Health Plan for Iowa, approved by the OCHP Advisory Council, was mailed in September to the presidents of all county medical societies in the state, and a copy of the Health Manpower Plan has been made available to members of the Society's Executive Council. The Committee commented on these documents in its report to the House last year.

The Committee chairman has served as one of the Society's representatives on the Advisory Committee/Family Nurse Practitioner Project, which was co-sponsored by the IMS and the Iowa Hospital Association, with funding from the Iowa Regional Medical Program. The pilot project was brought to a successful conclusion in September, and the six registered nurses who participated in the program are now working as FNPs in Iowa. Five are associated with the physicians who served as their preceptors, and the sixth is also employed in Iowa. An evaluation of the FNP program will be undertaken during the coming year by Sister Mary Brigid of the Iowa Hospital Association, who served as project coordinator, to determine whether use of the FNP can help to increase the availability of primary health services in rural Iowa.

The Committee had opportunity to review and comment on the initial draft of a section on Osteopathy and Medicine included in the Iowa Health Manpower Plan. The Plan was developed by a special committee of the State Office for Comprehensive Health Planning. Physician members of the committee were: John Tyrrell, M.D., Chairman; C. W. Seibert, M.D., J. H. Sunderbruch, M.D., and J. C. MacQueen, M.D. The IMS Committee was also provided a listing of proposed strategies and recommendations for alleviating health manpower shortages in Iowa and was invited to submit any recommendations or comments to the OCHP committee.

The Committee has been provided information regarding the statewide medical education system for family practice, and is pleased to note that residency programs are now underway in Cedar Rapids, Davenport, Des Moines, Mason City, Sioux City, Waterloo, as well as Iowa City.

Representatives of the College of Medicine confer often with IMS staff regarding physician recruitment and placement activities of the IMS and the College. Cooperation and liaison has been established in order to enhance the effectiveness of both programs.

The Committee will continue its interest in the broad area of the "delivery of health services" to the citizens of Iowa, and will meet at any time with appropriate state officials and agencies, and voluntary provider organizations to discuss various programs in this regard.

MAX OLSEN, M.D., *Chairman*

COMMITTEE ON DRUG ABUSE

In accordance with an action taken by the House of Delegates in 1975, the Committee on Drug Abuse is developing a paper on the prescribing patterns of Iowa physicians for presentation at the 1976 Scientific Session, and future publication in the IMS JOURNAL. The paper will be based on statistical and other data compiled by the University of Iowa College of Pharmacy regarding the 15 most commonly prescribed psychotropic drugs dispensed in 100 Iowa pharmacies.

The Committee met last fall with officials of the Iowa Drug Abuse Authority to discuss problems of mutual concern to the IDAA and the medical profession. It was reported to the Committee that the IDAA conducted a 4-month study of drug use and abuse in Iowa. The study focused on the prevalence, frequency, and situational context of the use and misuse of both psychotropic and illicit drugs.

The results of the study indicate that Iowa residents are most likely to experience problems associated with the relaxants/minor tranquilizers, the non-controlled narcotics, and the barbiturates. It also points to the relatively high rate of apparent medicine sharing, and the high rate at which prescription drugs are being taken other than as prescribed. A follow-up study to assess any trends in substance use, attitudes and knowledge is contemplated.

The IDAA has had preliminary discussions with the University of Iowa Colleges of Medicine, Pharmacy and Nursing regarding the development of an interdisciplinary course on drug use and abuse—e.g., prevention, treatment, resources, etc.—and the course curriculum is developed.

The Committee is scheduled to meet late in February, and IDAA officials will again be in attendance.

F. W. BENNETT, M.D., *Chairman*

COMMITTEE ON EYE CARE

The Committee will hold a meeting prior to the House of Delegates and any items that require action by the House or should be submitted for information will be included in a Supplemental Report.

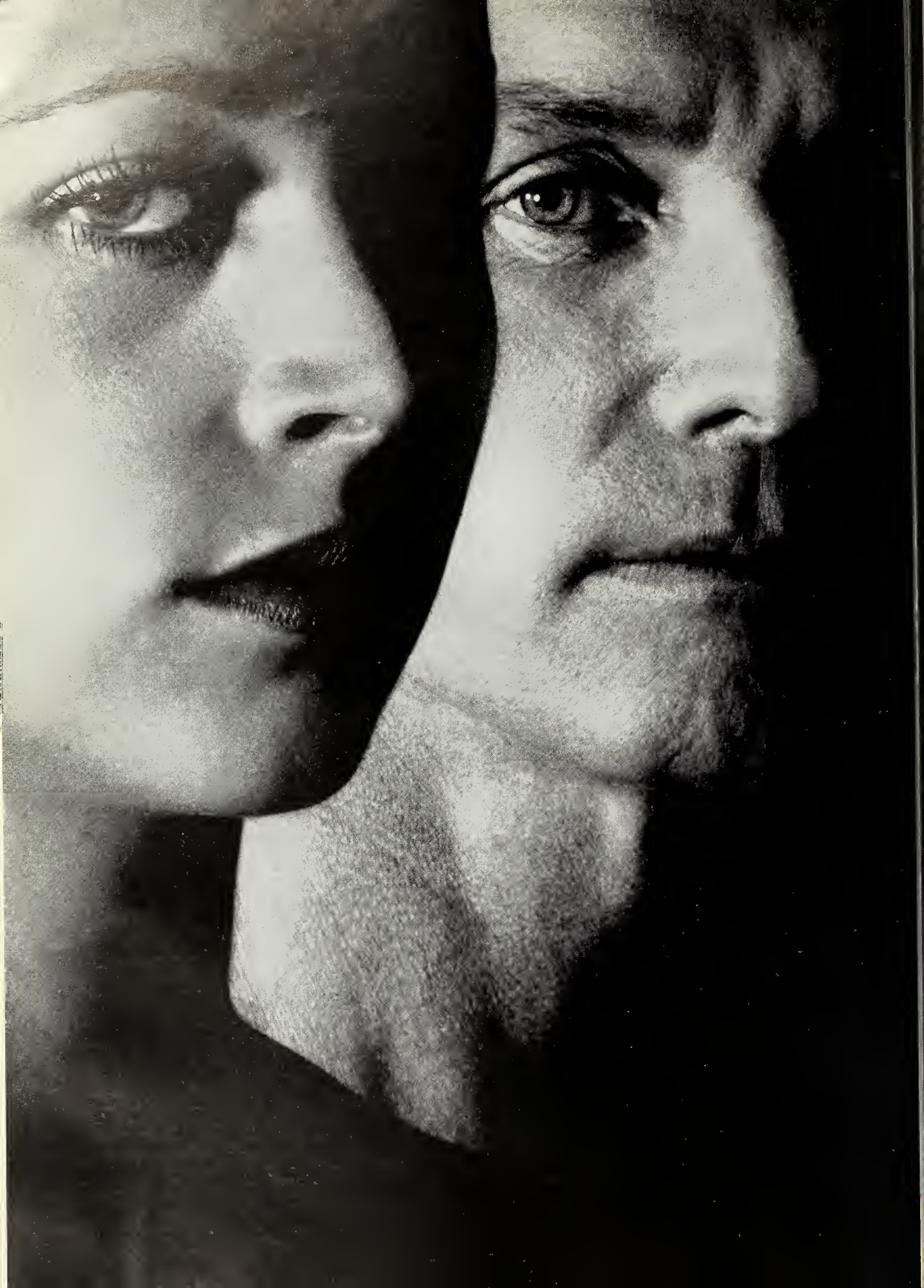
Several items have been reviewed by the Committee, including a presentation by the Pennsylvania Optometric Association to the State Advisory Council on Comprehensive Health Planning. In the statement, the Pennsylvania optometrists request that optometry be considered as the "primary point of entry" for all eye patients and that optometry stands ready, willing and able to enter into the field of "diagnosis and treatment of eye diseases." Essentially, they state the involvement of the ophthalmologist is only with major medical problems and surgery. These unfounded statements appear to be a part of a national effort to allow optometrists to use "diagnostic drugs." It is perhaps naive to think the use of "diagnostic drugs" is the ultimate goal in view of statements which appear to point toward the diagnosis and treatment by optometrists of most eye diseases and to assume even more of the current office practice of medical eye care. The Committee will continue to monitor these and other trends including third party programs for eye care.

A. H. DOWNING, M.D., *Chairman*

COMMITTEE ON GROUP INSURANCE

The Committee on Group Insurance continues to maintain surveillance over the various insurance programs which are available to Society members. Members are encouraged to relate these IMS coverages to personal circumstances to see if they may be of benefit.

The Prouty Company of Des Moines is active as administrator of the largest number of the Society's group insurance coverages. Efforts have been made in 1975 to inform IMS members of the benefits of the several programs. New member kits have been compiled to inform these physicians of what is available.



Testing in Humans: Who, Where & When.

The weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

It is possible to report continued improvement in the Disability Income Plan during 1975. Steps to correct a significant loss experience were instituted in 1972. Some necessary participation by younger members has been achieved. This increased penetration is essential due to overall age factors and to the incidence of retirement.

The Prouty Company expects to institute several improvements in the Disability Plan in 1976. One of these will be a Rehabilitation Benefit Rider. This will be available at no charge and will permit use of a rehabilitation program to be agreed upon by the insured and the company. It will consider additional living costs, tuition, books, etc., to cover retraining. This program would be supplementary to, and not in lieu of, the regular benefits.

A further new option of the Disability Program will be the availability of additional benefits without regard to health condition. This option will be available to the insured (in the amount of either $25 or $50 per week as selected by the insured) at two-year intervals between the ages of 28 and 42. This option will involve a one-time charge as part of the initial premium and should be particularly attractive to younger members. A special open enrollment period will be offered in 1976 to focus attention on these new benefits.

There have been increased benefits in the IMS Office Overhead Plan in 1975. Monthly payments were increased from $1,500 to $2,000. The maximum benefit period was increased from 15 to 24 months at no additional charge. Increased cost of office operation has sparked a new interest in this coverage.

The Society's group life insurance plan continued to expand in 1975. This coverage is underwritten by The Bankers Life of Des Moines.

The serious problem with the IMS Excess Major Medical Plan is controlled for the time. The Prouty Company offered a transfer from the Individual Excess Plan to a new Group Rated Excess Medical Plan with improved benefits and controls. Most of the insureds transferred to the new plan in 1975. This coverage remains under careful review.

There has been some refinement made in the IMS Statewide Physicians Group Health Program in the past several months. This coverage is provided by Blue Cross-Blue Shield. The modifications have been made as a result of the experience analysis which showed the following dollar use of the program:

Program Income	$152,257.62	$114,090.80
Program Experience (Claims Paid & Incurred Operating & Contingency)	169,279.80	146,048.29
Loss	$ 17,022.18	$ 31,957.49

After analyzing these developments, the Committee requested BC/BS to provide two benefit options. Option A (the current comprehensive benefit structure) has been made available for $27 and $70.30 (single and family monthly rate). Option B (a restricted benefit structure) is available for $21.55 and $55. It is the belief of the Committee these options will allow the participants to consider both benefit and cost factors. It has been explained that a mixing of the options is not possible within an office or clinic.

The Workmen's Compensation Savings Program begun in 1974 has enrolled additional physicians. This coverage is available through the Dodson Insurance Group. The first savings or dividend payment was made to the initial participants in the fall of 1975.

R. S. GERARD, M.D., *Chairman*

HISTORICAL COMMITTEE

The Historical Committee invites members of the IMS to visit the President's Conference Room in the IMS headquarters building, which contains the pictures of all IMS presidents, dating back to 1950, the Society's centennial year, as well as two Iowa physicians who served as President of the American Medical Association—Walter L. Bierring, M.D. and Donovan F. Ward, M.D.

The Committee encourages county medical societies to maintain records of their activities and to prepare manuscripts dealing with the history of medical practice and medical society organization in their areas. Any physician or county society with documents of this nature are urged to provide copies to the IMS for inclusion in its library. The Committee will be pleased to reproduce limited quantities (25-50) of historical papers for use by both the author and the IMS.

OTTO N. GLESNE, M.D., *Chairman*

COMMITTEE ON INDEPENDENT LABORATORIES

The Committee on Independent Laboratories has had one or two matters referred to it this past year.

An inquiry from the Iowa Hospital Association relates to the required establishment of paternity for illegitimate children receiving public assistance. Federal regulations provide for the use of blood tests in these cases. The regulations further require the identification of laboratories which perform these tests on a medically acceptable basis. A listing of such laboratories is to be made available. Working through the Iowa Association of Pathologists, the Committee is seeking to obtain a list of these laboratories.

The Committee has on file the Statement of the American Medical Association on S. 1737—The Clinical Laboratories Improvement Act of 1975. This statement declares AMA opposition to the bill on which hearings have been held. The bill would revise in its entirety the Clinical Laboratories Improvement Act passed in 1967.

The matter of acceptable proficiency testing as required of independent laboratories participating in Medicare has been noted in materials received from the College of American Pathologists. Also further notation has been made of a communication from the State Department of Health which reemphasizes the establishment by Medicare of minimum qualifications for clinical laboratory technologists employed in any independent laboratory. Several options are available to the technologists who work in a non-hospital independent laboratory. One approach involves the successful completion of an examination; this exam was offered in November.

G. R. CLARK, M.D., *Chairman*

COMMITTEE ON INDUSTRIAL HEALTH

Reports have appeared in the media in recent months citing an apparent growing number of refusals by Iowa physician specialists to perform examinations on persons who have been injured on the job. The problem was disclosed in January by State Industrial Commissioner Robert Landess. He indicated in the press that a significant backlog of claims is building up in the area of Workmen's Compensation.

The problem of physician liability was cited by Commissioner Landess as one possible reason for the increased difficulty in getting medical opinion on work-related injuries. He reported however it is essential that competent medical opinion be available to evaluate persons who claim to have been injured in the performance of their jobs.

The Committee on Industrial Health has communicated to Commissioner Landess its desire to assist in alleviating the situation. A meeting with state officials has been proposed and the Commissioner has reacted favorably to this idea.

Communication has occurred this year between the Iowa Foundation for Medical Care and the Office of the Industrial Commissioner regarding ways in which the Foundation might provide its peer review expertise to the Commissioner. There also has been discussion of the development of a universal form to be used in filing disability claims.

SIDNEY BRODY, M.D., *Chairman*

MD-DO LIAISON COMMITTEE

The Committee had scheduled a meeting in September, but circumstances caused it to be cancelled. The Committee continues to function as an information source whenever questions regarding relationships between MD's and DO's arise. Most questions are satisfactorily handled at the local level and do not require involvement of the state committee.

Approximately 30 osteopathic physicians and surgeons are active dues-paying members of the Iowa Medical Society and several more are active members of county medical societies.

J. M. RHODES, M.D., *Chairman*

MEDICAL ASSISTANTS ADVISORY COMMITTEE

The IMS continues its active support of and interest in the American Association of Medical Assistants, State of Iowa, Inc.

A "Medical Assistants" section is published each month in the JOURNAL OF THE IOWA MEDICAL SOCIETY reporting on various programs and activities of the organization, and a written expression of support is published in the annual convention programs of the AAMA. Representatives of the IMS also attend annual meetings of the state chapter.

Jeanne Greene, who has been my medical assistant for over 25 years, was recently honored by the national organization of medical assistants by being elected as its Vice President.

The AAMA represents approximately 16,000 individuals who work under the direct supervision of licensed physicians. These assistants serve as a direct link between the doctor and his patients, his colleagues, and suppliers of medical equipment and pharmaceutical products.

JAMES F. BISHOP, M.D., *Chairman*

COMMITTEE ON MEDICINE AND RELIGION

The Committee on Medicine and Religion did not meet during this year, and no new projects have been initiated.

A major objective of the Committee is to encourage physicians and clergymen at the local level to get-together on a formal or informal basis to discuss patient care problems. The existence of good communication and rapport between the patient and the clergyman can lead to more effective care and treatment of the "whole" patient.

The Committee chairman is pleased to note the educational programs that have been included in the curriculum at the University of Iowa College of Medicine on subjects relating to ethics, morals and religion.

The Committee is anxious to assist any county medical society in developing medicine and religious projects at the local level, and would be happy to participate in joint sessions involving physicians and clergymen.

O. E. SENFT, M.D., *Chairman*

COMMITTEE ON ONCOLOGY

Mobile screening for breast cancer (and the use of thermography in this connection) was before the Committee on Oncology last year. The Iowa Division, American Cancer Society, was reported to be considering a feasibility study to assess the merits of such a screening program. No further information has been received on this subject. However, a new policy has been set by the American College of Radiology which limits the use of thermography in the detection of breast cancer. This development is worthy of notation.

The ACR has joined with the American Thermographic Society to declare that thermography is a complementary diagnostic tool that may be useful in the evaluation of breast disease when combined with both physical examination under the supervision of a qualified physician and mammography by a trained radiologist. The two groups have determined thermography is not an adequate screening method for the detection of breast cancer or other breast disease when used alone or when combined only with physical examination.

The Iowa Medical Society has received inquiries from physicians regarding cancer treatments and medications brought to their attention by patients. Information has been supplied in each of these instances. The American Cancer Society booklet entitled, "Unproved Methods of Cancer Management," has been useful in answering these questions.

The Committee has on file a memorandum from the American College of Surgeons which is described as a position statement on Cancer Patient Care Evaluation. This statement contains two recommendations from the ACS Commission on Cancer which call for (1) hospital screening criteria and (2) the production in 1976 of at least one complete audit by each hospital cancer committee of a major anatomical site.

The Society has had contact in recent weeks with John Berg, M.D., who is directing cancer detection activities and programs at the University of Iowa. Dr. Berg has been encouraged to submit data he has collected for possible publication in the JOURNAL OF THE IOWA MEDICAL SOCIETY.

G. R. CLARK, M.D., *Chairman*

COMMITTEE ON ORGAN TRANSPLANTATION

The rate of kidney transplantation in Iowa continues at approximately 60 per year, of which 80% are cadaver transplants. Our reservoir of recipients is increasing in number, which is a reflection of our inability to get adequate numbers of cadaver kidneys.

Through the Iowa Medical Society, and in conjunction with the Kidney Foundation of Iowa, several interesting pieces of legislation have been introduced this past year.

House File No. 1053 is a bill to allow space on the driver's license for affixing a decal or sticker to signify the individual is a donor under the Uniform Anatomical Gift Act. This indicator would signal that a donor card is in the billfold of the accident victim. It appears this legislation has a good chance of passage.

The Iowa Medical Society, through the Transplantation Committee, has supported legislation which would recognize cerebral death. This has been considered for the past several years, and it appears that there is renewed interest in this legislation. Senate File 1075 has been introduced in this session. It is important to distinguish between a *definition* of brain death and *recognition* of same.

It is hoped that the legislation being introduced will stress the recognition of brain death.

There is an imperative need for continued public and professional education regarding the donation of cadaver organs. The membership of the Iowa Medical Society should recognize the inferred professional responsibility to a large group of patients on dialysis (150) who will need a cadaver organ to survive.

R. L. LAWTON, M.D., *Chairman*

PRECEPTORSHIP COMMITTEE

The Preceptorship Committee of the Iowa Medical Society met February 16, 1976, in Iowa City with Harold Moessner, M.D., Assistant Professor, Department of Family Practice, and Richard Caplan, M.D., Associate Dean, University of Iowa College of Medicine, to review the College of Medicine Preceptor Program, of which Doctor Moessner serves as Course Director. Under the program, medical students are required to complete a two-week preceptorship with a primary care physician within the third year in medical school; in addition, an elective preceptorship is available to senior medical students.

The Committee was advised that the following steps have been taken with respect to the program:

1. It has been decided that the third-year required preceptorship must be served in Iowa; however, students will have the option of selecting a preceptorship out-of-state during their senior year.

2. An effort has been made to up-date the list of approved physician preceptors, and letters have been mailed to all family physicians in the state to determine their interest in participating in the program.

3. Potential preceptors will be informed of the objectives of the program, and their role and responsibilities as teachers. A videotape has been produced, and will be shown at meetings of the Family Practice Club/Iowa Academy of Family Physicians, and other appropriate forums. The first showing occurred at the Family Practice Club session scheduled in conjunction with the 1976 Family Physician Refresher Course at the University of Iowa, February 17-20. An exhibit on the Preceptor Program has also been designed, and will be available for showing at various medical meetings in the state.

4. Last summer, students who were not participating in the MECO (Medical Education and Community Orientation) program for freshmen and entering freshmen medical students were invited to serve a one-week preceptorship with a physician in private practice, and approximately 10 students took advantage of the opportunity to do so. A similar invitation will be extended again this summer.

The Committee responded favorably to the information outlined above, and it was agreed that the IMS should supplement these activities, as follows:

1. A letter from the IMS president will be mailed to all physicians who are designated as preceptors expressing appreciation for their involvement in the program, and seeking their help in explaining to their students the importance of becoming active in organized medicine, with emphasis on locating in Iowa and membership in the IMS. A brochure explaining the purpose and activities of the IMS will also be provided to the preceptors in the event they would want to pass it on to their preceptees.

2. It was recommended that positive consideration be given to a suggestion that preceptors be provided a certificate acknowledging their participation in the Preceptor Program.

A report was also presented on the "Primary Care Preceptorship Program for Faculty" which was initiated a year and a half ago at the College of Medicine. Under the program, arrangements are made for interested faculty members to spend three days with practicing physicians in their offices; in turn, the local physicians can elect to spend additional time with their faculty "preceptees" at the College of Medicine.

The primary purpose of this activity is to provide opportunity for faculty members to spend time with physicians in private practice and learn about the problems confronting them in providing medical care in their communities. Those who have taken part in the program have found it to be a valuable learning experience. To date, 30 faculty members have served as "preceptees" and another two are scheduled for a 3-day preceptorship in April.

The April issue of the IMS JOURNAL is designated as the "University Issue" and reports on both the medical student and faculty preceptorship programs will be included in it.

The Committee chairman has been appointed to the Preceptorship Committee of the College of Medicine, which includes three faculty members, three physicians in private practice, and three medical students.

There was agreement that the IMS Committee should continue to serve in an advisory capacity to the College of Medicine, and offer constructive suggestions regarding the Preceptor Program and related projects.

L. D. CARAWAY, M.D., *Chairman*

COMMITTEE ON QUACKERY

The Committee on Quackery did not have occasion to meet this past year. Requests for information concerning questionable health practices and quackery are handled through IMS Headquarters.

The Committee is kept apprised of any pertinent health legislation, especially chiropractic proposals which are introduced in the Iowa General Assembly. No bills are currently pending.

A member of the Committee will participate in a special program on "quackery in cancer therapy" which is being arranged in Burlington, Iowa.

W. R. WHITMORE, M.D., *Chairman*

COMMITTEE ON RURAL HEALTH

The Committee on Rural Health wishes to call attention to a report of the American Medical Association concerning the availability of health services in rural areas. The AMA points out that mechanisms need to be developed in the more sparsely populated rural areas for sharing the services of medical personnel and facilities located in adjacent more densely populated communities. They state that the establishment by physicians of small group practices in areas of sufficient population density, with systematic arrangements for serving surrounding less populated areas, can be a more effective approach than temporary placement of a physician in every hamlet.

The Rural Health Committee has not been involved in implementing any specific projects; however, the Chairman also serves as Chairman of the Committee on Delivery of Health Services, which is also interested in studies and programs designed to assure the availability and accessibility of health care in rural areas—e.g., Model Regional Primary Health Care Center/Red Oak; utilization of physician's assistants and family nurse practitioners, etc.

MAX OLSEN, M.D., *Chairman*

COMMITTEE ON SPORTS MEDICINE

The Committee on Sports Medicine of the Iowa Medical Society has scheduled the third in its series of every-other-year Conferences on the Medical Aspects of Sports. The 1976 conference will be Thursday, April 8, in Des Moines at the Iowa Methodist Medical Center. The conference is a cooperative venture with the Iowa High School Athletic Association.

Keynote speaker for the conference will be Kenneth D. Rose, M.D., who has been associated with the athletic program at the University of Nebraska for a number of years. The conference is intended for interested Iowa physicians as well as high school coaches and trainers.

Additional matters to come before the Committee this year include:

1. *Proper Football Attire During Early Conditioning.* The Committee has advocated ideally a seven-day no-contact conditioning period to include a gradual introduction of equipment. The IHSAA has advised because of the time availability it will maintain its current schedule of four conditioning days in shorts, socks and shoes, but with no helmets. The issue was raised this past year when the football coaches requested an opinion on the wearing of helmets during this conditioning period.

2. *Osgood-Schlatter Disease.* The Committee has transmitted a brief statement on this disease which is prevalent among junior high age athletes. Such a statement was requested by the IHSAA for distribution to coaches.

3. *Football Play-Off Injuries.* The Committee has received a fairly detailed report on the number and severity of football injuries sustained during the high school playoffs. Questions regarding the prevalence of injuries were raised in connection with the playing of three or four games in a fairly brief time span. All 32 competing schools were surveyed with an injury incidence of less than 3 per 100 athletes, with some of these injuries requiring no medical attention.

4. *Wrestling and Weight Determination.* This topic continues to be of ongoing interest to the Committee. The practice of weighing in several hours prior to a match was questioned in inquiries directed to the Committee by several Mason City physicians. The recommendation has been made that an alternate matside weigh-in system be instituted. The possibility has been discussed with IHSAA representatives and they indicate they are aware of the Mason City recommendation. The Tipton approach to weight determination for wrestlers, which has been endorsed by the Committee for several years, is still regarded as the most desirable approach, but its complexity has resulted in limited acceptance.

5. *Nomination of Dr. Feldick.* The Committee has nominated one of its members, Harley Feldick, M.D., team physician at the University of Iowa, to receive the President's Challenge Award given by the National Athletic Trainers Association. Dr. Feldick has presented scientific material on football injuries at several recent national meetings.

The Committee invites the participation of interested Iowa physicians in the April 8 Conference on the Medical Aspects of Sports which is to be held in the Nursing School of the Iowa Methodist Medical Center in Des Moines.

ROBERT W. ANDERSON, M.D., *Chairman*

COMMITTEE ON VOLUNTARY HEALTH AGENCIES

The relatively inactive status of this Committee is more than offset by the involvement of a number of Iowa physicians in programs and projects of various voluntary health agencies. We are pleased to report that many IMS members serve in leadership roles in such organizations as the Iowa Chapter, American Cancer Society, Iowa Heart Association, Kidney Foundation of Iowa, Iowa Diabetes Association, etc.

It has been a custom in this brief report to encourage the state's medical practitioners to allow some of their time and expertise to assist worthy volunteer organizations in the health field.

As an example of the way in which the Iowa Medical Society collaborates with organizations active in a specific area of health care, there is a legislative proposal now before the Iowa General Assembly to facilitate organ donation. It is being supported by the Kidney Foundation of Iowa and the IMS. Several meetings involving representatives of both groups have been held to consider the matter.

Periodic inquiries are received from individuals who wish to know the existence of a specific health related organization. Effort is made to respond to these questions. Use is made of the AMA Directory of National Voluntary Health Organizations in this connection.

C. E. SCHROCK, M.D., *Chairman*

WOMAN'S AUXILIARY ADVISORY COMMITTEE

One of the principal purposes, if not the main one, of the Iowa Medical Society Auxiliary is to encourage and support the programs and activities of its parent organization. One such program which has stood the test of time and has served 325 Iowans is the medical student loan program of the Scanlon Medical Foundation/Iowa Medical Society. Because (1) of their primary purpose namely to serve the Iowa Medical Society, and because (2) of the importance of this loan program to the people of Iowa, and because (3) of the decreasing call upon the Auxiliary's HELF (Health Education Loan Fund) by those preparing for paramedical careers, it is the wish that those monies held in the HELF be given to the Scanlon Medical Foundation/IMS for use in its medical student loan program.

In a year that has required the undivided attention of physicians regarding legislative regulations being put upon them, malpractice insurance problems, and basically an attempt to change the complexion of medicine in the nation, the Auxiliary Legislative Committee has endeavored to serve the Iowa Medical Society. To be knowledgeable on health issues both locally and nationally has been their chief goal. Achievement in this effort was accomplished through monthly articles in their newsletter, periodic suggested reading lists, and through interested ladies in many counties keeping their members informed. Once knowledgeable, they have shared their views with our elected officials through a pyramidal system called LEGS (Legislative Effort Group System). The system provides a means of inundating our representatives with the views of the AMA and the IMS through personal letters, telegrams or telephone calls. The Auxiliary again hosted the wives of Iowa's lawmakers at a Legislative Brunch, where a health related program on health education in the schools was presented by Dr. John McCaw, Professor of Religion, Drake University.

The AMA-ERF Committee raises funds in various ways such as numerous projects, the solicitation of contributions and memorials, etc. The money that is raised through this committee helps increase the amount allotted the U. of I. College of Medicine and it adds to the loan guarantee fund which aids students seeking help in fi-

nancing their medical training. This year the Committee has taken in over $6,500 in donations and sales.

The Project Bank is a new concept of the AMA Auxiliary—still in its infancy stage. There have been some growing pains, but the idea is sound and will grow in its effectiveness for the IMS Auxiliary and its subsidiaries. The Project Bank theory is a sharing concept—a helping hand for doing the thing which the individual auxiliary wants to do—be it a health education community service project, a fund raising project to aid health related community agencies, or a project to promote friendly relationships and support to members of the individual group. Requests have come for information on projects listed in MD'S WIFE, child abuse and the history of medicine in the United States.

The International Health Committee has been busy collecting and assembling items that different relief organizations need for their work in world-wide health care. The Committee helps to supply the Iowa-Yucatan Partners of the Americas program with the medications and equipment needed for their medical missions. Current medical books and journals have been sent to people who have asked for help in obtaining materials for their medical libraries. Auxilians serve various relief agencies including New Eyes for the Needy.

The Public Affairs Committee is new and is designed for the purpose of getting information concerning any doctor who has been recognized for activities other than medicine. The plan is to compile a book recognizing these physicians.

The Volunteer Health Service Award each year recognizes a woman for outstanding volunteer service in the health field. This is an excellent public relations project at the county level inasmuch as nominations must originate at the county level.

Many other State Auxiliary committees have been working at their assigned tasks, and have been carrying on programs suggested by the National Auxiliary and approved by the IMS.

Iowa's Auxiliary continues to receive recognition on the national level. Mrs. Howard Ellis is chairman of the Long Range Planning Committee.

The Auxiliary and the IMS each have a president now. Last year there was a different one and next year there will be someone else. It matters little who is president one year or the other. It matters most that the blend and efforts of our groups shall endure to best serve our primary responsibility, the sick and injured among the people of Iowa.

The Committee was glad to be able to meet with the President of the Auxiliary. It was in agreement that the scheduling of sessions involving the IMS Advisory Committee and officials of the Auxiliary is beneficial and should be continued at least on an annual basis.

JAMES F. BISHOP, M.D., *Chairman*

(This concludes the material published in the HANDBOOK FOR THE HOUSE OF DELEGATES.*)*

Supplemental Reports

BOARD OF TRUSTEES

Section I—General Activities

Presented by A. J. Havlik, M.D.,
Chairman, Board of Trustees

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

The 1975 House of Delegates completed its business on May 1 at approximately 12:30 p.m. Now, here we are—precisely one year later—to assess what has been accomplished during the preceding 365 days, and to chart a course for the coming year.

The past 12 months have been busy and productive ones. The issues that have been discussed, the projects that have been undertaken, and the goals that have been achieved are well outlined in the Delegates' HANDBOOK. Even so, let's take a backward glance and look at some of the important issues and accomplishments:

SPECIAL SESSION/HOUSE OF DELEGATES

Even though the House adjourned its 1975 annual session on May 1, the delegates gathered together again on June 8 for a special meeting.

PROFESSIONAL LIABILITY

Professional liability was the single item for consideration at the special session. As a result, the House outlined specific recommendations in an effort to resolve some of the crucial problems confronting Iowa physicians, via appropriate legislative action, contacts with the insurance carriers and the Insurance Commissioner, and public and professional education.

The Board of Trustees was authorized, if necessary, to levy a special assessment not to exceed $100 per member to fund activities designed to thwart the professional liability crisis. Fortunately, there have been sufficient positive developments to preclude the imposition of an assessment on the membership. However, the increased cost of operation due to the professional liability problems did have an effect on the 1975 budget.

Although there are still difficulties—and these are not to be minimized—the professional liability situation in Iowa has stabilized. To date, we have good results with our legislative program, and a status report will be presented to you from the Legislative Committee later this morning.

It isn't totally fair to single out any one person or committee for a special accolade when much valuable work is being carried out in behalf of the Society by many important individuals and committees. However, the spotlight is on professional liability, and it is appropriate to recognize and commend the contributions of those who have worked so diligently for so long to relieve the pressures and resolve our professional liability problems. I refer particularly to Doctor Clarence Denser, Chairman, and the members of the Medico-Legal Committee; Doctor Don Young, Chairman, and the members of the Legisla-

tive Committee; Jim West, the Society's legislative lobbyist; and Eldon Huston and Don Neumann, who have primary responsibility for professional liability at the staff level.

IOWA HEALTH SYSTEMS AGENCY

Even though the IMS is well aware of the dangerous elements of P.L. 93-641 (Health Planning and Resources Development Act), as well as its potential ramifications with respect to the manner in which medicine might be practiced and "delivered" in the future, an effort has been made to provide leadership and counsel in the development of Iowa's Health Systems Agency, as prescribed by the law.

Doctors John Tyrrell and John McGee provided yeoman service as members of the HSA Interim Board. This interim body met at least a half dozen times from June 1975 to January 1976 to lay the groundwork and develop articles and bylaws for an incorporated board.

The medical profession should be proud and pleased that four M.D.'s were elected to the final HSA Board of Directors—Doctor John Tyrrell, who was also elected Vice President of the Board; Doctor Lawrence Ely, Doctor Russell Gerard and Doctor Paul Seebohm. Roger Rademacher, a D.O. from Charles City, is also a member, so the physicians of Iowa are well represented on this consumer-dominated Board of 30 members.

UNIVERSITY OF IOWA COLLEGE OF MEDICINE

Last year the House of Delegates approved a resolution relating to the continued maintenance of "close communication and positive intraprofessional relations between physicians at the College of Medicine, patients referred to physicians at the College of Medicine, and the referring physicians."

Officials of the medical school—specifically, Doctor John Eckstein, Dean; Doctor Paul Seebohm, Executive Associate Dean; and Mr. John Colloton, Director of University Hospitals and Assistant Executive Vice President for Health Affairs—responded immediately to this action by taking steps to enhance communications with physicians in private practice and their patients. Doctor Eckstein will give you the specifics later this morning.

I am sure the members of the House will want to join the Board in expressing sincere appreciation to Doctor Eckstein, officials, and faculty at the University Hospitals and College of Medicine for their positive understanding of and response to the concerns expressed by the Delegates last year. This is indicative of the high degree of cooperation and common endeavor that exists between the Iowa Medical Society and the College of Medicine.

For many years there has been a regular exchange of information, and a close liaison has existed between officials and staff of both the College and the IMS. This will certainly continue. In addition, it should be pointed out a very significant percentage of the clinical medical faculty are members of the state society, and approximately 30 committee positions are currently held by faculty members.

In Iowa "town and gown" problems are minimal, but when they do occur we should remember that communication is a two-way street, both at the "official" level, and also between individual physicians from the College and the community.

CONTINUING MEDICAL EDUCATION

The focus is on continuing medical education, and the Legislative Committee will bring us up-to-date on legislation that requires professional and occupational licensees to participate in continuing education as a condition for license renewal.

Last year, recognizing the increasing importance of providing access to programs accredited for Category I credit hours, the House authorized the IMS, through its Committee on Medical Education and Hospitals, to seek AMA approval and authority to accredit qualified institutions and organizations in Iowa which conduct CME programs for physicians. Subsequently, the accreditation program developed by the committee was approved by the AMA.

Last fall, informational materials were provided to the chiefs of all medical staffs, to presidents of county medical societies and medical specialty organizations, and to certain voluntary health associations. One hospital applied for accreditation and underwent a site survey; as a result, it is being recommended for a two-year period of accreditation for its CME activities. This action will not be announced officially and publicly until it has been ratified by the AMA Council on Medical Education later in the spring. Approximately 20 additional hospitals and one specialty organization have also expressed an interest in becoming accredited for CME.

In further reference to continuing medical education, special attention is called to the outstanding scientific program which was held in Iowa City on April 6, 7 and 8; and to the excellent scientific articles that appear each month in our own IMS JOURNAL.

RELATIONS WITH ALLIED HEALTH GROUPS

I've always been taught it's not nice to talk about one's relations, but in this case the report is positive.

Good liaison has been maintained with the Iowa Hospital Association, both at the officer and staff level. Last December the 103-page AMA booklet titled "Physician-Hospital Relations" was mailed to the chiefs of all hospital staffs in Iowa, along with a summary of a legal brief on the subject which pertains specifically to physician/hospital relations in Iowa. The summary was also provided to county medical society presidents. The AMA booklet provides guidance for resolving intra-hospital conflicts involving physicians, governing boards of hospitals, and hospital administrators.

This material was reviewed with the president of the Iowa Hospital Association, and copies were provided to the IHA for resource. Although nothing definite has been decided, consideration is being given to arranging a special conference next fall on the subject of hospital/medical staff relations and other matters of mutual interest, co-sponsored by the IMS and IHA.

Representatives of the Society, the Iowa Nurses' Association, and the Board of Nursing continue to meet on a regular basis. Members of the Society's Committee on Delegation of Authority have had an opportunity to give guidance and counsel on matters relating to the expanded role of the nurse, with particular attention to amendments to the Nurse Practice Act proposed by the INA. As a result of the close liaison that exists, the committee was effective in deleting some undesirable language from the original bill, without a negative reaction from the nurses.

Another committee of the Society—Delivery of Health Services—is studying the role and utilization of "physician extenders"—i.e., family nurse practitioners and physician's assistants. As outlined in its report to the House, the committee hopes to undertake an evaluation of the efficiency and effectiveness of such personnel, and draft a formal IMS position statement for future action by the Executive Council or House of Delegates.

Earlier this year a revised edition of the "Physician/Pharmacist Code of Understanding" was printed and dis-

tributed to all members of the Iowa Medical Society and Iowa Pharmaceutical Association. Documents like this are a valuable tool in strengthening interprofessional cooperation and support.

Eldon Huston, EVP of the Society, succeeded Donald Taylor as secretary-treasurer of the Iowa Health Council last fall. The Council is comprised of nine health care provider organizations. Although the member groups may not always see "eye-to-eye" on individual health care issues, the Health Council does provide a forum for the discussion of our common concerns. In addition to Mr. Huston, two physicians represent the IMS on the Council's board of directors.

COMMUNICATIONS

This past year, increasing attention has been given to enhancing our communications with the membership. We have always strived to keep the members informed on the activities of the Society and the critical issues confronting medicine, but we have learned the truth of the old adage: "You can lead a horse to water, but you cannot make him drink!"

Voluminous amounts of written materials—letters, bulletins, reports, etc.—are distributed through the headquarters office, and our telephone lines are "hot" all day long. In addition, society officers—mainly Doctor Schlaser and Doctor Bishop—have spoken at several county society meetings, and special conferences were arranged at various times during the year for key county and state medical society leaders.

Because of the importance of our communications program, we have developed a special report on what is currently being done to maintain close contact with the membership, and the public as well, and proposals for the future. Doctor John Kelley will make this presentation to you.

Section II—Communications

Presented by John H. Kelley, M.D.,
Member, Board of Trustees

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

INTRODUCTION

Few of the Iowa Medical Society's 126 years have passed without a comment about the need for effective communication. And as the years pass, the complexity of medical care delivery increases—making the task of communicating more of a challenge. It boils down to the future of our medical profession depending heavily on its ability to inform, inspire and involve its member physicians.

In 1975 and 1976, the Board of Trustees has involved itself actively in the communication process, and it has given extra thought to the future. It is for these reasons the Board has prepared a separate section of its supplemental report on intraprofessional communications.

At the outset, we need to remind ourselves that nearly all Iowa Medical Society endeavor represents communication in one form or another. It may be oral, by personal letter, on a face-to-face basis, by telephone, on a one-to-one basis, in group settings, in published or printed form, at Society Headquarters, at county society meetings, etc. Out of this is formed the opinion of the rank-and-file member as to the worth of the Iowa Medical Society. With so many forms of communication inter-meshing, it is difficult to measure the effectiveness of individual efforts.

Combined with the need to communicate effectively with member physicians is the companion task of reaching important non-medical audiences, e.g., legislators, the press, allied health personnel and the general public. What the IMS says to these groups is heard or read by the member physician and has a rebounding influence. For example, the contents of a published "letter to the editor" from the Society president has perhaps more impact on the physician reader than it does on the lay reader.

It is obvious that effective communication necessitates planning, investment and thoughtful execution.

OBJECTIVES

Certain inter-related objectives must be sought in a well-conceived intraprofessional communications program. Included here should be efforts:

1. To provide member physicians with useful and understandable scientific and socio-economical material.
2. To inform the membership regarding policies, programs, events and other developments which bear on the profession as it delivers medical care in Iowa.
3. To foster awareness and enlist member support of Society actions and positions on current health care issues.
4. To develop conscious and/or unconscious pride among Iowa physicians in the constructive program of their professional organization.

In a consideration of these objectives, it must be acknowledged that a percentage of our colleagues will support the Society with their dues but have little or no incentive beyond that. To what extent this disinterest exists is not known. Nonetheless, in our array of objectives must be one to arouse the interest of the physician who believes his full schedule rules out even a considerate reading of the mail. We must hack away at the so-called apathy problem.

1975-76 COMMUNICATION EFFORTS

No claim is made that the past year has been remarkably different from others of the recent past. However, the following brief inventory of 1975-76 Society programs and published material will give the House of Delegates a useful overview. We recognize your familiarity with these items. But we believe that seeing them in a total sense will aid any assessment you may make.

Special Programming—This past fall the Board of Trustees advised county society officers it would welcome invitations to county meetings to present brief or extended informational reports. Mainly through the efforts of the president and president-elect, this project to "take the mountain to Mohammad" has been successful. Visitations were made to 25 county medical societies representing approximately 80 per cent of the physicians in the state.

This officer visitation program was combined with a corresponding effort to bring "Mohammad to the mountain." In 1975-76, several informational programs were presented at IMS Headquarters for different physician groups. Included here have been conferences for county society officers, legislative contact men, new member physicians and specialty society officers. These programs brought to IMS Headquarters not only many loyal and long-active members, but also a number of newly-involved physicians.

Published or Printed Communications—Much of what is being provided to members in print form has existed for many years. The efforts with journals, bulletins, etc., are similar to those of other states. Obviously, the larger

states have the resources to support a more impressive array of printed material.

To give you a perspective in this area, in 1975-76, the following items were sent to member physicians one or more times:

1. IMS JOURNAL—2,800 copies are printed monthly by The Ovid Bell Press, Inc. The JOURNAL and the annual Scientific Session are the Society's most conspicuous attempts at continuing education. The scientific writing in the JOURNAL is almost entirely that of Iowa physicians. The JOURNAL'S appearance has been relatively constant since some overhaul several years ago. The production cost per month averages about $1,500. Advertising and other income (about $20,000 annually) helps to offset these costs.

2. *IMS News Bulletin*—This familiar goldenrod sheet is distributed to the full membership approximately 12 times a year. It is not issued monthly but rather is sent when an event or issue is believed to deserve reporting. It does have a scheduled nature however in that it is used to summarize meetings of the AMA and IMS Houses of Delegates after they occur, to provide essential information about the nomination and election of officers, etc.

3. *IMS Legislative Bulletin*—While green in color, this bulletin takes the same appearance as the News Bulletin. As the name suggests, it concentrates on legislative developments. It is sometimes distributed to the full membership, but more often is limited to legislative contact or other special audiences.

4. *IMS Report*—This is a monthly two-page summary of current Iowa medical care developments. Its principal distribution is to county society officers, delegates and other physician leaders. It is also sent to the College of Medicine for the medical students.

5. *IMS Mini-Message*—This is a quickie-type of communication instituted this year. It is quite easy to handle and inexpensive. It is approximately postcard size and has been used to relay a one- or two-paragraph message.

6. *IMS Roster*—The most recent roster of Society members was issued last fall. Each member received a copy. This is the Roster's second printing in this size and form. It lists members alphabetically and geographically by county

7. *Miscellaneous Informational Material*—Additional material is prepared each year for various use. 1975-76 involved considerable activity of this type. Special mailings have been made to county presidents on HSA, hospital/medical staff relations, immunization activity, etc. In addition, we have sent the full membership an IMS Fact Sheet, an IMS 1975-76 Calendar of Events, a Physician/Pharmacist Code of Understanding, programs for the Scientific Session, the recent Sports Medicine Conference and the Fall Conference. We also have an IMS Informational Booklet and an IMS Organizational Booklet which are used on a specialized basis. Finally, this year we have placed in folder form various of the "In the Public Interest" features from the JOURNAL and have distributed them to all members. We have indicated these folders are available for further distribution to patients—and have had requests for 4,000 or 5,000, principally for the one dealing with medical liability.

EVALUATION

We have reviewed here the basic components in the IMS communications program. Now the question becomes, Is the desired result being achieved? Are member physicians being provided what they want and need in relation to available resources? We can only answer with informed opinion. No recent attempt has been made to survey physicians in this area. Preliminary thought has been given to this need by the Board and survey activities in other states have been assessed.

RECOMMENDATIONS

This report has attempted to highlight current Society activity in the communications area. We believe further attention is in order. In this connection, a request is made for the reaction of the House to the current program and a response is invited to the following five recommendations:

1. That the title—JOURNAL OF THE IOWA MEDICAL SOCIETY—be changed to IOWA MEDICINE to provide a new, concise and more vibrant designation. In this connection, the contents page would retain clear reference to the former title and carry a statement that this is the official publication of the Iowa Medical Society.

2. That in the coming year the JOURNAL and perhaps other Society communications be measured as to member interest and acceptance following a form to be determined by the Board on the basis of cost and effectiveness.

3. That, depending on findings from any survey, consideration be given to converting the JOURNAL into a publication for both physician and patient readers. In its current conceptual form, this new publication would contain articles on medical care developments in Iowa. As now conceived, the magazine would retain a scientific thrust to the extent of including one well-chosen scientific article for easy removal by the physician. The total publication, when the physician completed his personal review, would be suitable for patient reading in reception rooms.

The economics of this new publication are a major uncertainty. The handling of advertising will need extensive consideration and will obviously bear significantly on the feasibility. A mock-up of the magazine is available and will be shared with members of the Reference Committee. We ask only for informal reaction to the idea at this time.

4. That the Board be encouraged to explore more effective written communication with IMS members. In this connection, the Board has agreed that the *IMS Report* be supplanted by a new monthly communication to be called *IMS Update*. This four-page self-mailer will be sent to all member physicians, not just officers, as has been the case with the *IMS Report*. A sample of the proposed *IMS Update* has been prepared and is included in the packet.

5. That the Board of Trustees be supported in a continuation of 1975-76 efforts (a) to present information at sites around the state, and (b) to conduct conferences, seminars, etc., for physician groups at IMS Headquarters.

Please be mindful the Board is anxious to provide informational and educational material in a form which is desired by the members. We are of the opinion that some experimentation may identify effective new approaches. In this total effort a conscientious approach will be made to the use of Society resources.

At this point, Mr. Edwin Hass, western sales manager for Sandoz Pharmaceuticals, Inc., presented Sandoz medical journal award to Dr. Marion E. Alberts, Scientific Editor, JOURNAL OF THE IOWA MEDICAL SOCIETY. *The* JOURNAL *was cited for excellence of design, editorial content and concise editing.*

Section III—Finances

Presented by Hormaz Rassekh, M.D.,
Member, Board of Trustees

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

In October of 1973, the Iowa Medical Society House of

Delegates increased the dues of member physicians by $50. This action established the dues level at $200 as of January 1, 1974. In authorizing the increase, the House indicated its wish that the following objectives be achieved:

1. To reverse the deficit financing pattern which developed as a consequence of the accelerated mortgage payment program;
2. To restore the IMS to a sound ongoing fiscal condition upon completion of the mortgage payment process;
3. To eliminate an approximated $90,000 float (this began in 1967 with each ensuing year's dues used to meet current year operating costs); and
4. To establish a reserve fund.

The degree to which these objectives have been met may be noted as follows:

1. The IMS headquarters building is clear of indebtedness;
2. In 1974 and 1975, the $90,000 float noted in No. 3 above was eliminated;
3. A reserve fund of approximately $70,000 has been established; and
4. The 1976 IMS budget provides a $24,000 addition to reserve plus a small excess of income over expenses. (See attached 1976 budget.)

It is the judgment of the Board of Trustees that (a) the directions of the House of Delegates have been followed in fiscal management, and (b) prudence has been used in guiding the Society's financial affairs. The matter of inflation has been and is crucial. The inflation factor the past two years totals 19.2%. Disregarding this factor, Society expenditures for programs and services have increased only 3% in the two-year period.

In planning for 1977 and beyond, the Board of Trustees has taken cognizance of the following factors and submits them to the House of Delegates:

1. While inflation shows signs of abating, its impact on Society budgeting will still be significant. Most experts predict inflation of 6 to 7% in 1976. A corresponding level in 1977 will require approximately $30,000 additional dollars to operate the Society at the present level.

2. The IMS staff has been decreased from 20 persons in 1970 to 12 full-time persons in 1975. The Society has seven part-time staff, represented primarily by the IMS/Blue Shield joint field force. Specific staff modifications have included (a) retention of a legislative counsel rather than a full-time staff lobbyist; (b) reduction in the IMS/Blue Shield field service staff; and (c) use of secretarial personnel on a judicious basis with part-time help obtained on occasion.

Even with these staff reductions, the Board believes IMS programs and services have been in general held at the existing level, and, in some instances, have been increased and/or enhanced. Additional staffing will need to be considered if new programs or activities are added to those now in existence.

3. In 1975, the House of Delegates authorized the Board of Trustees to collect a $100 assessment to defray costs incurred in the professional liability program. After evaluating legislative and other developments associated with the medical liability situation and the administrative mechanics of handling the assessment, the Board elected to defer the implementation of this program. Consequently, the Society's 1975 expenses do reflect increased expenses in connection with professional liability efforts. (See attached breakdown of 1975 expenses.)

4. Any further curtailment of Society activities must be weighed carefully in terms of jeopardizing the broad program. A definite effort has been made to identify priorities and to give principal attention to the ones considered most acute. In view of the constant and increasing pressures, both state and national, the Society must be as active and aggressive as possible.

5. IMS participation in conferences, seminars, and special events is important, both at the state and national levels. The number of regional and national conferences attended by IMS representatives in 1970 numbered 25 and in 1975, the number of meetings attended by Society representatives was reduced to 10. Additional reductions in expenditures for this activity may be instituted, but they could produce adverse results. In this area, it should be recalled that by House authority the IMS sends three (3) delegates and three (3) alternate delegates to the two sessions of the AMA House of Delegates each year. Prior to this House action, only one alternate delegate was elected and attended AMA meetings. As stated, the number of IMS representatives authorized to attend national or regional meetings has been reduced considerably. Further limitations may be possible; however, the point is near at hand when such action will jeopardize the Society from the standpoint of having an active and involved leadership.

6. The number of eligible dues-paying members has decreased from 2,170 in 1966 to slightly more than 2,000 in 1975. The eligible non-members in 1966 were 86 in number; the eligible non-members in 1975 totalled 316. It is difficult to attribute this increase in eligible non-members to a less effective program or organization. Some of this total is represented by better record-keeping which occurs now. In many instances, the hike in eligible non-members is the result of frustration and the feeling of futility. In other cases, it is a lack of understanding of the Society's program and achievement. The downward trend in Society membership may have been reversed in 1975. It is too early to tell if the one-year stabilization will continue. The Judicial Council and Board of Trustees have given preliminary consideration to the concept of "unified membership" which is in effect in several states. It is felt this approach is worthy of consideration in Iowa.

7. A crucial aspect of member recruitment and retention involves the ability of the Society to convey its message to Iowa physicians. The Board of Trustees is undertaking a review and evaluation of IMS communications with an obvious eye toward improvement. Financial restraints will bear on the degree to which innovation may be undertaken in this area.

8. It is significant to note the dues of various health-related organizations in Iowa exceed those of the IMS. Coupled with this is the fact that several state medical societies now have dues which surpass those in Iowa. For example, Wisconsin has increased its dues to $300 per member, essentially for the purpose of establishing what is being called a Physicians Alliance Division. Minnesota has increased its dues to $225 per member, also to add more staff.

9. The IMS headquarters building is now 10 years old. Obviously, in this time only minor repairs and limited refurbishing have been needed. Heavy use of the building in recent years gives indication that some redecorating, etc., may soon be in order to provide a facility representative of the medical profession.

It is the opinion of the Board of Trustees that the present dues level can be maintained through 1977. This statement is based on two premises: (1) that no heavy demands be made for additional services and programs, and (2) that continuing conscientious attention be given to limiting expenditures. This means there will be no provision for the addition of any executive administrative staff. And even with the application of these cautious and restrictive fiscal measures, it is likely some funds will need

to be taken from reserves to meet 1977 operating costs.

It appears almost certain, if the IMS is to function at its present or a higher level, a dues increase will be required in 1978. Society dues were $125 in 1965; they were increased to $150 in 1969, and raised to their present level of $200 in 1974. In this time, the Society is believed to have been as active in behalf of the medical profession as at any period in the organization's history. At the same time, the Society has fully underwritten the acquisition of land and the construction of a headquarters building (with a purchase value of over $420,000). The Board of Trustees regards this as excellent performance.

It is essential that the House of Delegates understand as fully as possible the financial status of the Society. The future course of the Society is dependent upon informed responses by the House of Delegates to the recommendations of the Board of Trustees. After serious consideration of the several options, and in view of all factors, the Board of Trustees submits the following recommendation:

That membership dues in the Iowa Medical Society for 1977 be maintained at the present level of $200 per member, recognizing that with such action a restriction will need to be placed on additional services, programs and staff. Further, based on present circumstances, a dues increase in 1978 will be necessary with the exact amount to be determined by the 1977 House of Delegates.

More detailed expense and income figures are available for examination by the reference committee and other delegates. The Board of Trustees is prepared to discuss the points contained in this report in as much depth as may be desired.

(Resumption of the report by Dr. Havlik.).

As a part of the Board's Supplemental Report, it is always a pleasure to include information regarding the activities of the Iowa Foundation for Medical Care, which the House actually created several years ago. It is a pleasure to present to you the President of the Foundation, Doctor Kenneth E. Lister, of Ottumwa, who will give us some up-to-date information on PSRO activities of the Foundation and other matters of interest.

1975 EXPENSES

1. Staff Salaries and Employee Benefits		39.7%
Salaries	33.0%	
Benefits	4.9	
Social Security	1.8	
2. Officer, Committee and Staff Expenses		12.8
Staff	3.2%	
Field Service	2.8	
Officer	2.7	
Committee	2.0	
Trustee	1.4	
Council	.7	
3. Legislative and Legal Expense		10.1
Legislative	7.4%	
Legal	2.7	
4. Reserve Funds		9.4
5. Building Taxes, Repairs, Maintenance, Insurance and Utilities		8.0
Taxes	2.8%	
Repairs & Maint.	2.3	
Lights, Gas & Water	1.7	
Insurance	.9	
Service Contracts	.3	
6. Office Stationery & Supplies, Postage & Telephone		6.8
Telephone	2.6%	
Postage	2.2	
Stationery & Supplies	2.0	
7. Journal		4.7
8. Other Expenses		8.5
Scientific Session	2.4%	
Auxiliary	2.0	
County Society Services	1.6	
House of Delegates	1.1	
General Admin.	.8	
Dues & Subscript.	.6	
		100.0%

FINAL COPY—1976 BUDGET

Account	Monthly 1976 Budget	Total 1976 Budget
INCOME:		
Dues—State Society	$ 33,330.00	$400,000.00
Interest on Investments	1,100.00	13,200.00
Miscellaneous Income	60.00	720.00
AMA Collection Commission	320.00	3,800.00
Total Income	$ 34,810.00	$417,720.00
EXPENSES:		
Annual Scientific Meeting (Net)	$ 200.00	$ 2,400.00
Council Expense	350.00	4,200.00
County Society Services	500.00	6,000.00
Depreciation, Building & Equipment	2,000.00	24,000.00
Dues and Subscriptions	250.00	3,000.00
Employee Pension, Disability & Health Programs	1,900.00	22,800.00
Field Service (Net)	1,200.00	14,400.00
General Administrative Expense	300.00	3,600.00
House of Delegates	400.00	4,800.00
Insurance	350.00	4,200.00
Journal (Net)	1,330.00	16,000.00
Legal Services	900.00	10,800.00
Lights, Gas & Water	600.00	7,200.00
Office Stationery & Supplies	650.00	7,800.00
Postage	750.00	9,000.00
Repairs and Maintenance	900.00	10,800.00
Salaries (Net)	11,800.00	141,600.00
Service Contracts—Machines	120.00	1,440.00
Taxes:		
Personal and Property	1,050.00	12,600.00
Social Security and Unemployment	700.00	8,400.00
Telephone & Telegraph	900.00	10,800.00
Travel—Officer	1,300.00	15,600.00
Travel—Salaried Employee	1,200.00	14,400.00
Trustee Expense	400.00	4,800.00
Woman's Auxiliary	720.00	8,640.00
Committee Expense	2,750.00	33,000.00
Total Expense	$ 33,520.00	$402,280.00
Net Income for Period	$ 1,290.00	$ 15,440.00

REPORT TO IMS HOUSE OF DELEGATES IOWA FOUNDATION FOR MEDICAL CARE

K. E. Lister, M.D., President

(Referred to the Reference Committee on Insurance and Medical Service.)

Thank you, Dr. Havlik. It is a pleasure to address the House on this, the fifth anniversary of the Foundation's creation. I am pleased to report that the purposes assigned the Foundation at the House of Delegates meeting in April, 1971, have been realized. As can be determined from this report to the House today, the Foundation has become a viable instrument of the profession in dealing with third-party insurance companies and government. We shall continue to carry forth the role set forth for the Foundation in its original charter and look forward to another five years of continued progress in peer review.

The Foundation has completed the contracting phase of its PSRO duties and is beginning to implement the program. We negotiated a contract in December, 1975, and exchanged signatures with HEW in January, 1976. The total dollar amount of the contract award is less than expected but still is sufficient to permit us to institute a review system with many hospitals. We received approximately $580,000 which will support PSRO efforts with approximately 50 hospitals. Since signing the contract with HEW, there have been some major changes in PSRO financing which may permit us to work with more hospitals if the implementation schedule permits.

The Foundation is in the process of evaluating hospital review plans to determine those eligible for what is termed a "delegated status." Delegation means the hospital has authority to administer its own review activities, and claims are submitted to the intermediary without fear of retroactive denial. The only monitoring a delegated hospital is exposed to is a summary review required by the PSRO to determine if the hospital is continuing to operate effectively.

The selection of delegated hospitals is to be made by a committee of the Foundation Board. This committee is composed of representatives from each of the Foundation's district peer review committees. In addition, there is a representative of the Iowa Hospital Association and an osteopathic physician. The committee will coordinate its evaluation activities with the local peer review unit as it seeks to ascertain a hospital's eligibility for delegated status. The Foundation is most impressed with the level of activity and the degree of sophistication many hospitals and medical staffs have developed. This will make the job much easier and permit implementation of the PSRO program in an expedient and efficient manner.

The Foundation has continued to perform fee review for physicians, patients, and insurance carriers. During 1975, the Foundation resolved over 1,100 cases through the peer review process. There has been an increase in the number of physicians requesting peer review. This is a positive trend and hopefully will continue as physicians recognize the ability of the Foundation to resolve fee questions which may arise with an insurance company. The physician will become more inclined to ask the carrier to submit the case for adjudication by the Foundation. The Foundation continues to work with most of the major commercial carriers in the state and with Blue Shield. Enclosed in your packet is a more detailed summary of what has transpired in peer review this year. I invite you to look at this report to see how your Foundation is performing.

During the past year, the Foundation has studied how it can best meet the organizational requirements of a PSRO. It is necessary to revise the Articles of Incorporation and Bylaws to meet some specific provisions of the PSRO law. These changes were reviewed with the Executive Council, and I will briefly highlight them for the House. It is our intent to present these changes to the Foundation membership for ratification later this month.

The most important change has to do with the Board structure. The PSRO law provides that all positions on the Board must be determined through election by the membership. Thus, a change will need to be made in the present arrangement wherein the IMS trustees hold automatic membership on the Foundation Board. It has been proposed that the IFMC Board be restructured into seven districts. These districts have been modified from the present six peer review districts. From these districts, Board positions will be slotted to permit both county and areawide representation on an apportion basis. In addition, three positions have been slotted for oestopathic representatives. The number of Board members will total 23 as compared to the present twenty (20). This new structure offers the advantage of geographical representation and guarantees that all physicians, both metropolitan and non-metropolitan, will have an equal voice in policy-making.

Other changes in the bylaws pertain to membership requirements, the election process, and committee structure. These changes are not major and do not significantly alter the intent of the House when it formulated the Foundation's corporate charter.

The Foundation continues to contract its peer review services to organizations desiring to use them. We have operated on this basis since the Foundation assumed responsibility for peer review in 1972. Currently, we are funded by HEW for PSRO program activities. In addition, we receive funds from health insurance companies who subscribe to the peer review service. It is our intent to increase the private activity to relieve the dependence upon governmental funding. We are presently working on a

PEER REVIEW REPORT
Calendar Year 1975

	Cases
FIRST LEVEL REVIEW	
Prior Pending December 31, 1974	262
Submitted During 1975	1,022
Resolved During 1975	1,131
Withdrawn Cases	31
Pending December 31, 1975	122
FULL COMMITTEE REVIEW	
Prior Pending December 31, 1974	36
Submitted During 1975	
Carrier	31
Physician	80
Resolved During 1975	125
Withdrawn Cases	16
Pending December 31, 1975	6
BOARD OF DIRECTORS REVIEW	
Prior Pending December 31, 1974	9
Submitted During 1975	
Carrier	7
Physician	20
Resolved During 1975	31
Pending December 31, 1975	5*

* Of the five pending, four are pending review by the Board of Trustees of the Iowa Dental Association.

mechanism through which the Foundation can recover administrative costs when applying its PSRO monitoring program to the private sector. As yet, we have not been able to finalize these financial arrangements.

The Foundation does have a matter of specific business to bring before the House. During Board deliberations this past year, we have become aware of a lack of clear policy regarding the Foundation's authority to recommend to health insurance companies claims payment guidelines which differ from or modify guidelines previously adopted by the Iowa Medical Society House of Delegates. Our intent in bringing this to the attention of the House is to have the matter clarified during this session.

In May, 1972, the House formally adopted a resolution which provided for the transfer of peer review responsibilities from the IMS to the Foundation. Since that time, we have served to develop and operate a peer review system which we believe is both efficient and equitable. We have passed through several phases of maturity, but we feel the program has always shown progress.

As a part of our efforts to administer peer review, the Foundation has identified several problems and issues which need policy consideration. Because of the rapid changes in both the technical and economic aspects of the health care system, some of these matters have become acute. In response to these needs, peer review sometimes reflects itself through individual case recommendations. Usually these decisions, if they do vary from established policy, are brought to the Board's attention for overall policy determination. It is at this point we find some confusion in the degree of authority placed with the Foundation.

To be totally effective in our peer review process, we feel the Foundation must have clear authority with insurance companies and others in the performance of peer review. This is not stated without knowledge of the consequences such authority could bring to the Foundation. We recognize claims payment guidelines and other policy matters are not casually developed. They result from much study and hearing so that all involved parties have part in the decision-making process. In addition, once policy has been decided it should be applicable over a long period of time.

Thanks to strong support and direction from the IMS, the Foundation has become a viable and recognized instrument of the medical profession. Our membership includes close to 70% of the practicing MD's and DO's in the state—truly a representative portion of the Iowa licensed physicians. As explained earlier, the Foundation is restructuring its Board to provide fair area representation and proportionate representation from MD's and DO's.

The Foundation is pleased with those relationships it has developed with the health care financers in the state. We have maintained an almost daily discourse with Blue Shield, with most of the major commercial insurance car-

PEER REVIEW REPORT BY CARRIER
Calendar Year 1975
First Level Review

Carrier	*Pending as of 12-31-74*	*Submitted*	*Resolved*	*Withdrawn*	*Pending as of 12-31-75*
Aetna (Davenport)	34	97	127	1	3
Aetna (Des Moines)	12	23	33	1	1
Bankers	63	188	228	5	18
Blue Cross-Blue Shield	29	286	270	8	37
Connecticut General	14	11	24	1	–
Cooperative Health Association	–	2	2	–	–
John Deere	40	185	179	6	40
Employers Mutual	–	1	1	–	–
Equitable	12	11	22	1	–
Federated	1	–	1	–	–
General American Life	–	1	1	–	–
John Hancock	1	8	8	–	1
Hartford	–	4	4	–	–
Iowa Industrial Commission	1	1	2	–	–
Iowa Labors District Council	–	1	1	–	–
Liberty Mutual	–	2	1	–	1
Lincoln National Life	–	1	1	–	–
Medicaid	16	10	25	1	–
Medicare	–	21	19	–	2
Metropolitan Life	–	1	1	–	–
New York Life	–	56	54	–	2
Pacific Mutual	–	1	1	–	–
Protective	1	–	1	–	–
Prudential	7	33	35	1	4
Sentry	–	2	2	–	–
Travelers	31	76	88	6	13
Total	262	1,022	1,131	31	122

PEER REVIEW YEAR-END REPORT
Calendar Year 1975 by District

	First Level Review						Full Committee Appeal Summary						
	Pending as of 12-31-74	Submitted	Withdrawn	Resolved	Pending as of 12-31-75	Yearly Median Days	Pending as of 12-31-74	Submitted (C)	Submitted (P)	Withdrawn	Resolved	Pending as of 12-31-75	Yearly Median Days
District I	45	156	7	183	11	71	3	–	4	2	5	–	
District II	24	187	7	171	33	49	4	4	8	–	15	1	56
District III	43	198	5	229	7	36	19	9	9	9	28	–	83
District IV(A)	95	358	7	391	55	81	6	14	49	2	64	3	125
District IV(B)	7	31	–	35	3	45	1	2	1	2	1	1	
District V	40	55	3	80	12	57	1	1	9	1	9	1	
District VI	8	37	2	42	1	54	2	1	–	–	3	–	
Total to Date	262	1,022	31	1,131	122	60	36	31	80	16	125	6	125

riers, and with the largest self-insured group in the state —John Deere. These relationships are based on a mutual respect for the intent of peer review. All carriers have the option to accept peer review findings or to appeal any case to a higher level of review. Of course, all final appeals are resolved by the Board of Directors. We feel this broad representation throughout the insurance industry makes possible a valuable communication's link with almost the entire third-party financing system.

The Foundation Board recommends the House of Delegates permit the Foundation to exercise authority in recommending policy changes and claims payment guidelines to insurance companies. This authority should be outlined specifically in a formal memorandum of understanding to be reached with the IMS Board of Trustees based on direction given by the House of Delegates. This memorandum would include such things as the Foundation's role in policy-making, assurances that proposed claims payment guideline recommendations have had sufficient hearing, and that policy decisions receive broad dissemination among the profession.

We further recommend the House refer to a reference committee for consideration of Foundation policy actions as they are brought to the attention of the House of Delegates. It is our strong desire to continue to seek the guidance and support of the Iowa Medical Society. Only by actively working together can we serve both the medical profession and the public.

K. E. LISTER, M.D.
J. H. BRINKMAN, M.D.
J. H. SUNDERBRUCH, M.D.
T. F. DYNES, M.D.
M. H. DUBANSKY, M.D.

(Resumption of the report by Dr. Havlik.)

Over the years the Iowa Medical Society has worked closely with Blue Shield of Iowa, and an excellent relationship exists between our two organizations. It is a privilege to introduce Doctor Christian E. Radcliffe, Chairman of the Blue Shield Board of Directors, who has several matters of interest and concern to discuss with us.

BLUE SHIELD OF IOWA
REPORT TO IMS HOUSE OF DELEGATES

C. E. Radcliffe, M.D.,
Chairman, Blue Shield of Iowa Board of Directors

The purpose of this report is to highlight the major achievements of Blue Shield of Iowa during the past year. These achievements establish our continued efforts to provide quality health care in a cost effective manner and to develop benefit programs that meet the needs of our members.

Many factors contribute to the success of Blue Shield of Iowa, but perhaps the most outstanding factor is the strong support and leadership provided by the Iowa Medical Society. With the other members of the Blue Shield of Iowa Board of Directors, I would like to thank this House of Delegates for the direction provided in the development of more effective mechanisms for health care delivery.

The year 1975 for Blue Shield of Iowa can be summed up in one simple word—achievement. Overall, we operated in such a manner that we were able to use more of our subscribers' health care dollar for benefits. We processed more than $126 million in benefits for our own members and for beneficiaries of Government Health Care Programs. Blue Shield members, in fact, received more than $75 million in benefits representing some 1,734,075 claims for physician services. This claims load amounts to an increase of nearly 20% over the previous year. Including Major Medical payments, Blue Shield of Iowa paid out over $81 million for physicians' claims.

The 1975 level of benefit payments represents a sound increase of $16 million in medical and surgical payments over 1974's total.

In addition to payments made for claims incurred under our regular lines of business, another $33.3 million was disbursed for physicians' services provided under the Medicare Part B program, $10.7 million under the Medicaid program and $999,000 under the CHAMPUS program for military personnel.

More and more Iowans continued to turn to Blue Shield of Iowa in 1975 for professional health care coverage. For our Blue Shield Plan, the year resulted in a net gain of 36,893 members, bringing total enrollment to a record 1,236,286, or 43% of the population of the state. When participants in government programs are added to private business participants in an unduplicated count, Blue Shield of Iowa serves approximately 1.7 million people, or 54% of all Iowans.

As encouraged by this House of Delegates, we have increased the number of participants under age 65 with UCR contracts to over 93% of the total, up from 90% one year ago.

Our Major Medical program, which offers $250,000 in

lifetime benefits, covered over 716,000 people in the state at the end of 1975, a sound growth of 54,000 participants over 1974. Approximately $6 million in Major Medical benefits were paid last year, amounting to an increase of $800,000 in benefit payments over 1974's total.

We attribute our membership and benefit growth to the continuous involvement and support of the Iowa Medical Society, to the direction provided by the practicing physicians and lay representatives of the Blue Shield of Iowa Board of Directors, and to our strong working relationship with Iowa's physicians. We also recognize the outstanding leadership and dedication provided by Bill Recknor, Executive Director of Blue Shield of Iowa, and by the entire administrative staff. Certainly we realize that accomplishments such as those marked by Blue Shield of Iowa in the past years are attained only through a cooperative effort to reach clearly defined goals.

In addition to the outstanding leadership rendered on behalf of Blue Shield of Iowa, another factor contributing to our successful operation is that we are constantly working to develop new coverage programs to make sure our members have the best protection available. In accordance with requests from the Iowa Medical Society, we have studied alternate delivery systems in an attempt to experiment with new methods of delivery for subscribers and providers.

Last year served as a special landmark in the development of alternate delivery systems with the opening of Rural Health Services (RHS) in Bloomfield. In addition to working with physicians and other health care providers to develop this program, the Plans are performing all administrative and marketing functions. We are gratified by the receptiveness of the people to this new form of health care delivery and by the marketing success registered by RHS in its first months of operation. We began marketing the program in November 1975 and enrollment projections estimated 4,000 enrollees for the first year of operation. As of March 1, 1976, 3,914 people had enrolled for RHS benefits, representing 56.7% of the under 65 population of Davis County.

One great advantage of this delivery system to the patient is that it brings together in a single organization the physicians, hospitals, technicians, laboratory and other medical facilities so that patients are able to get the right care at the right time. The Plan provides subscribers with a broad range of health services for a fixed payment, including most inpatient and outpatient care, office and home visits, prescription drugs and ambulance service. Physicians participating in the program are paid on a capitation basis each month and hospitals are paid on a charge basis according to their usual rate schedules.

Last year we reported on another ADS project, namely, the Patient Assessment and Diagnostic Evaluation Program, which is a pilot program developed in cooperation with hospital and medical representatives at Mercy Hospital in Des Moines. The PADE concept offers Blue Cross and Blue Shield subscribers outpatient coverage for specified diagnostic x-ray, laboratory and other procedures, as well as the doctor's fee for professional diagnosis. The program's purpose is to determine the patient's illness as an outpatient instead of as a bed patient, thereby reducing the number of hospital admissions which, in the eyes of physicians, could be treated on a cost effective outpatient basis.

The PADE program was initiated August 17, 1975, and as of March 31, 1976, Blue Cross and Blue Shield of Iowa estimated that nearly 500 patient days had been saved as a result of the PADE program.

We are encouraged by the progress of this new alternate delivery system and view the program as a success at this time, basically because we are able to make payment to patients for services provided on an outpatient basis through the cost savings generated by the reduction in the number of inpatient hospital days. We will continue to stress ambulatory care benefits and other alternate delivery systems because people must be encouraged to get quality care in the least expensive way. Quite logically, that means care received as other than an inpatient.

Last year this House of Delegates suggested that we send copies of the Explanation of Benefits to all nonparticipating doctors each time a Blue Shield claim is processed. We have responded by implementing procedures that enable us to provide this service as a benefit to nonpar doctors and our subscribers. Through receipt of the EOB, the nonpar doctor now can determine whether or not the claim has been processed accurately and can review information on procedure code, charge for the service, the Blue Shield allowance and the reason for any amount or services not covered. We are pleased that the general reaction of physicians throughout the state has been very favorable.

The 1973 House of Delegates promoted the adoption of a CPT coding system by Iowa physicians for all the third party claims. Blue Shield of Iowa worked with IMS and the AMA to develop the five digit code, plus modifier and narrative description. This coding system allows the physician to more accurately designate the many services he performs and, as a result, Blue Shield of Iowa is able to construct more accurate fee profiles and to administer more equitable service payments. Advantages obviously accrue to the patient, the physician and Blue Shield of Iowa.

The conversion to the CPT coding system took place March 15, 1975, at which time 27% of the claims received by our Claims Department for private Blue Shield business were pre-coded with the new system. At the end of 1975, approximately 54% were pre-coded and in the first three months of this year the number of pre-coded claims reached 62%. That is, in one year pre-coded claims increased from 27% to 62% of the total. Our staff is gratified by the receptiveness of physicians to adopt this new code and, in order to maximize the usefulness of a good system, will continue educational efforts by the professional relations representatives and the training department.

One year ago a committee of the Iowa Medical Society endorsed the establishment of a procedure for making equity fee adjustments to physicians based on the cost for malpractice insurance. We responded by allowing physicians who qualify to receive additional monies to offset precipitous increases in malpractice premiums.

As of April 21, 1976, 199 physicians had applied for the equity fee adjustment, for which 110 were approved. The denials were returned because the physicians involved did not meet the requirement established by the Insurance Department to have a 300% increase in malpractice rates in two years. Because of the stop-gap nature of this program, equity fee adjustment requests were accepted only until April 1. We sincerely hope this measure alleviated the present crisis but, on a larger scale, we continue to hope that an answer to the malpractice question is found that will be reasonable and acceptable for all parties involved—physicians, patients and third party payors.

As you are well aware, the cornerstone of the UCR system is the physician's usual charge. To ensure that the Blue Shield usual profiles are as accurate as possible, we are now providing physicians with two printouts of their most current recorded usual fees. These printouts serve to verify the information stored in the computer and to provide physicians with the opportunity to validate and/

or correct charges for procedures. The first printout was mailed last fall and another is ready to be sent now.

As I stated, two printouts are mailed to each physician —one for the office file copy and the duplicate for submission to Blue Shield of Iowa with updated usual fees. The printouts include those procedures for which the physician has either submitted a usual fee or for which we have received claims. Specific information recorded are the CPT procedure codes, the narrative description, the appropriate modifiers and the charge currently recorded. An asterisk appears by those procedures for which the usual fee exceeds the customary allowance.

We request that physicians review these printouts carefully and record all corrections on the duplicate copy for submission to the Profile Administration Department of Blue Shield of Iowa. In order to properly record a fee update, the department needs the procedure code, nomenclature, new fee and effective date, which is most efficiently provided through corrections on the printout. We simply cannot grant across the board increases with no reference to specific procedure codes. Once the updated fees are recorded in the computer, the physicians will receive a new printout with his corrected usual fee schedule.

I would like to emphasize to physicians that the computer printouts of their most current usual fees apply only to private Blue Shield business and do not apply to government programs. As you are probably aware, the government programs maintain separate specifications relating to filed fee updates. Also, let me emphasize that physicians are allowed one manual update per procedure per calendar year, in addition to the two automatic updates.

One final point should be recognized on the subject of usual fee filings. Blue Shield of Iowa now requires at least 30 days advance notice, in writing, before a new usual filed fee increase can be recognized. This eliminates retroactive filed fee increases. The reason for this change is quite basic: We simply must have some time to get the information into the computer and to check its accuracy in order to process claims accurately and efficiently.

These modifications to our usual fee filing system were implemented to minimize claims problems relative to fee differentials. With the cooperation of participating physicians, the UCR program will continue to provide the best in professional health care coverage for Iowans.

In addition to input from physicians, management, Board Members and employees, Blue Shield of Iowa receives the ideas and suggestions of the statewide consumer advisory organization formed in 1974 to expand public involvement in Plan affairs. We reported on the activities of this organization last year and I would once again like to stress its importance to us as providers of health care services and health care coverage.

The organization consists of a 27-member state council and 12 area committees representing each of Iowa's 99 counties. The committees and the state council meet twice a year to discuss matters pertaining to the design and delivery of health care services. The committee and council members work on specific Plan problems, such as claim form simplification and language revision, and also provide an ongoing consumer attitude survey. In their consumer-oriented capacity, the strongest feedback involves the subject of cost containment—the need for it and . . . in so many words . . . the lack of it.

Consumers are, and always have been, involved in health care matters as patients, workers within the system, developers of fringe benefits, trustees and voters. Sometimes a consumer finds himself the holder of two diverse—even diametrically opposed—opinions. For instance, when a consumer is ill or injured, he wants all the myriad miracles his doctor and the hospital can produce. He reacts through pain and fear. But not ill or injured, or once well, he reacts strictly through his checkbook. As we are well aware, at any given time there are more people not using health care services than there are using them. The cost factor becomes dominant and the demand for cost containment programs rings loud and clear.

We are hearing the demand for cost containment not only from our advisory organization, but from other publics as well. Depending upon physicians for leadership and direction, Blue Shield of Iowa is committed to a deep involvement in activities that help stabilize the cost and improve the quality and availability of care for Iowans.

Before I close, I would like to acknowledge the Board of Directors of Blue Shield of Iowa, which is composed of 19 physicians and eight lay people. The expertise of our Board members provides the knowledge needed to be innovative, yet cost effective, in meeting the health care needs of Iowans.

Let me re-emphasize my appreciation to the House of Delegates and all members of the Iowa Medical Society for their support and many contributions to Blue Shield of Iowa. With your continued input and support, we look forward to the future challenges that will make Blue Shield of Iowa an even more important health resource for the physicians and people of the State of Iowa.

(Resumption of the report by Dr. Havlik.)

CONCLUDING REMARKS

This completes the Supplemental Report of the Board of Trustees. Even though the Delegates' HANDBOOK contains the written summary of a very busy year for the Society, the Board feels it is beneficial to take the time and make the effort to highlight some of the important aspects of IMS projects and business affairs.

The Board has one final message to leave with you, and it is this: The Iowa Medical Society has a well-earned and well-deserved reputation for being an active, productive and effective organization. We want to keep it that way. To do so, the support of all the physicians in Iowa is necessary. We must let our non-member colleagues know that even though they do not pay dues, they benefit directly in many ways from the activities and representations of the IMS. There is no excuse for apathy. And if a physician is not happy with what the Society is doing, then he should be encouraged to consider his choices—to stand aside and scoff; or to join and become actively involved in seeking the desired changes. Which shall it be?

A. J. HAVLIK, M.D., *Chairman*
V. L. SCHLASER, M.D.
J. F. BISHOP, M.D.
C. D. ELLYSON, M.D.
W. R. BLISS, M.D.
T. A. BURCHAM, M.D.
J. H. KELLEY, M.D.
H. RASSEKH, M.D.

At the conclusion of the report, Dr. Havlik presented a check for $18,244.17 from the American Medical Association Education and Research Foundation to Dr. John Eckstein, Dean of U. of I. College of Medicine.

John W. Eckstein, M.D.,
Dean, College of Medicine

Dr. Eckstein acknowledged receipt of the AMA-ERF grant with appreciation. He cited several uses made of the unrestricted grant last year. He mentioned faculty recruitment, curriculum evaluation and student exchanges.

Dr. Eckstein paid tribute to Herman Smith, M.D., Des Moines, for his valuable contributions to medical education.

Dr. Eckstein reported further on the resolution adopted by the 1975 House of Delegates which urged attention to communications between the University and referring physicians. He explained what the University has done in response to the resolution. He advised of the development and distribution of a document entitled, "Guiding Principles of Intraprofessional Conduct at the University of Iowa Hospitals and Clinics." This statement has been endorsed by the heads of all the clinical departments of the College of Medicine and the hospital administration. It will be used in the indoctrination each year of new faculty, residents, medical students, etc.

Dr. Eckstein also noted the distribution of a revised Physicians' Desk Reference Guide which contains telephone numbers of the various departments and each clinical faculty member. It sets forth the procedures to be followed in making appointments.

Dr. Eckstein concluded by indicating this new communication effort will be ongoing with regular surveying done to determine its effectiveness. He encouraged the Iowa physicians to relay comments and suggestions regarding the system.

Following Dr. Eckstein's remarks, Dr. Frank Jirka, Berwyn, Illinois, trustee of the AMA, spoke to the House of Delegates. His address appears on page 252 of the JOURNAL.

INFORMATIONAL REPORT ON THE SCANLON MEDICAL FOUNDATION/ IOWA MEDICAL SOCIETY

Presented by A. J. Havlik, M.D.,
President, Scanlon Medical Foundation/Iowa Medical Society

The activity of the Scanlon Medical Foundation/Iowa Medical Society has continued in 1975-76 toward the scientific, educational and philanthropic goals which have been established. This report is provided to summarize those developments which have occurred.

First, as regards the medical student loan program, which has been the Foundation's major enterprise through the years, the following statistical highlights are current and significant:

1. There are 11 Iowans receiving medical student loans this 1975-76 academic year. The total amount committed to these students is $16,500. The names of the current recipients, their hometowns and their classes accompany this report.

2. The actual amount of money loaned between 4/1/75 and 4/1/76 totalled $11,915. The money repaid during this period by loan recipients now in practice amounts to $22,887.14.

3. The money loaned by the Foundation since the program began totals $580,299.52. The money which has been repaid by loan recipients amounts to $274,598.16. The total amount of loan money outstanding as of 4/1/76 was $305,701.36.

4. There have been loans made to 317 Iowans through the years and 172 of them have now repaid their borrowings in full.

5. Total resources on loan to the Foundation from physicians, county medical societies, specialty organizations and the Iowa Medical Auxiliary is $53,803.62.

The Scanlon Foundation has seen its financial potential increased in several ways during 1975-76 and these are worthy of brief recognition.

1. The Cerro Gordo County Medical Society donated $8,669.34 (plus $586.53 in interest) to the Foundation on 8/15/75. This money had previously been on loan to the Foundation from Cerro Gordo County.

2. The Iowa Medical Auxiliary loaned $8,000 to the Foundation on 8/5/76. This is in addition to a $1,000 loan made previously. Further financial support from the Auxiliary will be noted at the conclusion of this report.

3. The Henry Albert Trust Fund has been a continuing source of funding for the Scanlon Foundation. In the period from 4/1/75 to 4/1/76 the money from this source has amounted to $7,484.03.

4. In 1973, the IMS House of Delegates authorized a voluntary entry of $35 on the Society's dues billing statement. Support from this source has reached its highest level this year with $17,340 having been contributed up to 4/1/76 by 495 physicians. This is compared with $12,825 from 367 contributors as of the same date last year. Memorials and contributions of other types have totalled $788 during the first three months of 1976. The Foundation Board is grateful for this increasing physician support of the Scanlon program.

The full financial report for the calendar year 1975 is provided with this summary.

In addition to the medical student loan program, several other projects have received continued support in 1975-

SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY
BALANCE SHEET—DECEMBER 31, 1975

ASSETS:		
Iowa State Bank & Trust Company	$ 11,494.40	
Central National Bank & Trust Company	10,975.91	
CNB Golden Passbook Savings	16,400.35	
Notes Receivable from Medical Students	308,063.56	
Student Nurse Loan Fund	3,701.63	
Total Assets		$350,635.85
LIABILITIES AND NET WORTH:		
Notes Payable to Physicians & County Medical Societies	$ 53,803.62	
Net Worth:		
Balance 1-1-75 $269,877.34		
Add: Net Gain for 1975 26,954.89	$296,832.23	
Total Liabilities and Net Worth		$330,263.77

SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY
Income and Expense Statement—December 31, 1975

INCOME:		
Contributions and Memorials	$ 17,745.56	
Henry Albert Trust	11,107.89	
Interest on Loans	5,105.49	
Interest on CNB Golden Passbook Savings	498.40	
The Prouty Company	250.00	
Cerro Gordo County Medical Society	8,669.34	
Miscellaneous Income	44.60	
Total Income		$ 43,421.28
EXPENSES:		
Public Service Projects—		
Hawkeye Science Fair	$ 4,500.00	
Medical Education Projects—		
Monthly Scientific Articles in IMS JOURNAL	$ 2,000.00	
Iowa Chapter, Student AMA	500.00	
Baldridge-Beye Lecture (IMS Scientific Meeting)	707.19	
Administrative—		
Iowa State Bank & Trust Company	$ 400.00	
Interest Paid on Loans from Physicians	2,439.30	
1975 Consulting and Staff Services	5,000.00	
Legal Services	748.00	
Audit and Tax Return	125.00	
Miscellaneous Administrative Expenses	46.90	
Total Expenses		$ 16,466.39
Net Gain for 1975		$ 26,954.89

SCANLON MEDICAL FOUNDATION/
IOWA MEDICAL SOCIETY
1975-76 STUDENT LOAN PARTICIPANTS

STUDENT	HOMETOWN	SOPH.	JR.	SR.
Blew, Stanley A.	Ottumwa		X	
Cranberg, Lee D.	Des Moines	X		
Herbst, John	Marion			X
Iverson, Nancy	Ottumwa		X	
Luepke, Brian F.	Emmetsburg			X
Pfeffer, John Charles	Cedar Rapids		X	
Quigg, Gary R.	Davenport	X		
Rogers, John J.	Davenport	X		
Whalen, Johanna Bond	Iowa City		X	
Wolfe, Steven L.	Hampton			X
Zurbriggen, Thomas L.	Elgin	X		

76. Included here are the Hawkeye Science Fair, the monthly Henry Albert Scientific Presentation in the JOURNAL, the Baldridge-Beye Lecture at the IMS Scientific Session.

The Board of Directors of the Scanlon Foundation will meet during this session of the House of Delegates to review the program. Those who now serve on this Board are L. H. Jacques, M.D., G. L. Baker, M.D., A. J. Havlik, M.D., J. H. Kelley, M.D., Hormoz Rassekh, M.D., R. L. Wicks, M.D., Ronald V. Saf, Ivan Johnson and D. L. Taylor.

A comment about one of these men is in order. Word has reached us that for health and other reasons, Dr. Jacques is relinquishing his position on the Board. Dr. Jacques has rendered valuable service to the Foundation since he succeeded Dr. Scanlon eight years ago as the Iowa City physician designated to interview the medical student loan applicants and authorize their participation in the program. Dr. Jacques has made himself readily available to the students for this purpose and has done a fine job in behalf of the Foundation. We certainly wish to acknowledge his excellent efforts in this report.

Finally, in addition to recognizing Dr. Jacques for his service, the Board is particularly anxious to acknowledge the support of the Iowa Medical Society Auxiliary in recent weeks. For many years, the Auxiliary has operated what has been called the HELF program—this stands for Health Education Loan Fund and has involved the granting of loans to persons in the paramedical or ancillary health fields.

On January 21, 1976, the Auxiliary Board of Directors approved the following motion:

MOVED, That the monies held in the HELF fund be given to the SMF/IMS (with the exception of the $8,000 loaned in 1975) for use in its medical student loan program, with the understanding that all present commitments of the Auxiliary to loan recipients will be honored and that further administration of the HELF program insofar as collecting outstanding loans will become the responsibility of the Foundation.

While the formal transition of these funds has not been completed as yet, the dollar involvement will be quite significant. Approximately $22,000 is involved in total; about $11,000 is now out on loan, another $11,000 is in hand with approximately $6,000 of this committed to loan recipients. The Foundation will assume the administration of the outstanding loans and will allocate money which becomes available to the medical student loan program.

Quite obviously, the Scanlon Foundation Board, and I am sure all Iowa physicians are grateful for this further support of the medical profession and its efforts to perpetuate itself. We wish to acknowledge this action of the Auxiliary by asking its president, Erlene Veverka, to come forward to represent her fellow members in accepting our appreciation. We invite Erlene to comment on this action and on other activities of the Auxiliary.

Mrs. Veverka highlighted the activities of the Iowa Medical Society Auxiliary.

Supplemental Reports of Standing Committees

(The Speaker asked the members of the House of Delegates to stand while J. E. Tyrrell, M.D., Chairman of the Judicial Council, read the names of the IMS members who died in 1975. The list appears on page 264 of this issue of the JOURNAL.)

NOMINATING COMMITTEE

The Nominating Committee of the Iowa Medical Society met on Sunday, March 28, 1976, and agreed upon the following slate to be presented to the House of Delegates today:

President-Elect
C. D. Ellyson, M.D., Waterloo
L. W. Swanson, M.D., Mason City

Vice President
A. W. Boone, M.D., Davenport
G. A. Paschal, M.D., Webster City

Speaker of the House of Delegates
L. D. Caraway, M.D., Amana

Vice Speaker of the House of Delegates
Charles Jons, M.D., Ames
J. H. Lohnes, M.D., Cedar Rapids

Trustee (Three-year Term)
A. J. Havlik, M.D., Tama
W. M. Krigsten, M.D., Sioux City

Delegate to AMA (Two-year Term)
(Two to Be Elected)
Erling Larson, M.D., Davenport
J. M. Rhodes, Sr., M.D., Pocahontas
J. R. Scheibe, M.D., Bloomfield (Name Withdrawn at Candidate's Request)

Alternate Delegate to the AMA (Two-year Term)
(Two to Be Elected)
J. R. Anderson, M.D., Boone (Name Withdrawn at Candidate's Request)
J. L. Garred, M.D., Whiting
E. B. Mathiasen, M.D., Council Bluffs
W. C. Rosenfeld, M.D., Mason City
J. R. Scheibe, M.D., Bloomfield

Councilor, First District (Three-year Term)
C. L. Kelly, M.D., Charles City

Councilor, Fourth District (Three-year Term)
D. M. Youngblade, M.D., Sioux City

Councilor, Sixth District (Three-year Term)
A. M. Dolan, M.D., Waterloo

Councilor, Eleventh District (Three-year Term)
A. L. Sciortino, M.D., Council Bluffs

Blue Shield Liaison Delegates to IMS
(Two to Be Elected)
C. W. Seibert, M.D., Waterloo
J. D. Ver Steeg, M.D., Des Moines
E. A. Motto, M.D., Davenport
J. R. Scheibe, M.D., Bloomfield (Name Withdrawn at Candidate's Request)

Additional nominations may be accepted from the floor after which the Speaker of the House of Delegates will declare nominations closed.

The Articles of Incorporation and By-Laws require that for candidates to be unopposed for nomination, they must be unanimously approved by the Nominating Committee. Although it is recognized that it is desirable to have two candidates as a minimum for each of the proposed offices, the Nominating Committee is submitting but one candidate for some offices since these were the only names formally proposed to the Nominating Committee and were unanimously approved by the Nominating Committee.

It will be noted that there are four candidates for the two offices of Blue Shield Liaison Delegate to the Iowa Medical Society. Under the Articles of Incorporation and By-Laws of the Iowa Medical Society, the Liaison Committee shall submit to the Nominating Committee the names of four or more candidates for the two positions of Liaison Delegate. Therefore, under the IMS By-Laws, it is mandatory that four or more names be submitted to the Nominating Committee for these offices. These names are merely received by the Nominating Committee and submitted as a part of its report to the House of Delegates.

L. O. GOODMAN, M.D., *Chairman*
J. W. BARNES, M.D.
C. L. BEYE, M.D.
J. H. BRINKMAN, M.D.
L. E. COPPOC, M.D.
KURT HAHN, M.D.
LEONARD LAMBERTY, M.D.
G. A. PASCHAL, M.D.
J. X. TAMISIEA, M.D.
D. C. YOUNG, M.D.

ADDENDUM

On April 5, 1976, the Board of Trustees received the resignation of C. E. Radcliffe, M.D., Iowa City, as Iowa Delegate to the American Medical Association.

Nominations to fill the vacancy created by the resignation of Doctor Radcliffe will be invited at the appropriate time during the opening session of the House of Delegates.

Nominations from the floor were requested and the following physicians were nominated for delegate to AMA to fill the unexpired one-year term of Dr. C. E. Radcliffe: Dr. John Anderson, Boone; Dr. Kenneth K. Hazlet, Dubuque; and Dr. George C. McGinnis, Fort Madison. Next, nominations were accepted for alternate delegate to the AMA and the following physicians were nominated: Dr. Clarence H. Denser, Jr., Des Moines; and Dr. Robert D. Whinery, Iowa City. These candidates were in addition to those appearing on the slate presented by the Nominating Committee.

COMMITTEE ON LEGISLATION

Dr. Donald C. Young, chairman of the IMS Committee on Legislation, presented an oral report from the Committee on Legislation for the delegates' information only, and Dr. Thomas E. Kiernan, Chairman of the Iowa Medical Political Action Committee, emphasized the need for physician support of candidates in the upcoming 1976 election and urged them to join IMPAC.

MEDICO-LEGAL COMMITTEE

(Referred to the Reference Committee on Articles of Incorporation and By-Laws and Legislation.)

Professional liability developments of the past six to nine months were summarized in the HANDBOOK report of the Medico-Legal Committee. This supplemental report will review the HANDBOOK summary and include further information presented at a meeting of the Medico-Legal Committee on April 15, 1976.

In addition to the committee members, those in attendance at the April 15 meeting included representatives of the State Insurance Department, the Aetna, Medical Protective and St. Paul insurance companies, and the Iowa Society of Anesthesiologists.

Following are highlights from the comments made by each of those noted above:

State Insurance Department: Mr. Julius Hoerster advised that few coverage problems have been submitted to the Insurance Department in recent weeks. He confirmed the tight nature of the umbrella or excess market. He endorsed the belief that House File 803 has helped to preserve the private market in Iowa. He confirmed that Hartford is withdrawing from Iowa, thus requiring approximately 60 physicians to find alternate coverage. He said the second of four reports to be issued by the National Association of Insurance Commissioners will be available soon; this study of all claims closed after July 1, 1975 is expected to be beneficial in identifying and supporting further remedial legislation. Mr. Hoerster advised the Department disapproved new rate filings for basic limits coverage submitted by the Insurance Services Organization. The disapproval occurred on February 18, 1976. The Department approved the ISO excess limits filing (representing an 18.5% increase) on December 11, 1975. The ISO filings represent a reference point for rate making by the individual carriers.

Aetna Insurance Company: Mr. Bob Reiber reported no significant underwriting changes have been made in Iowa by Aetna within the past six months. He indicated the company's fiscal picture has improved with less underwriting loss in 1975 than in 1974. He advised the Aetna is seeking ways of staying in the market and is reasonably satisfied with its Iowa experience. The company is tending to view group sales more favorably than unit or individual sales. Aetna now has eight state-sponsored, group-type programs. Mr. Reiber stressed that Aetna has not denied limits of coverage to any of its insureds; however, the excess limits coverage is written only over the company's basic policy. Coverage of new physicians has been limited essentially to those doctors joining Aetna-covered groups; about 70 new doctors have been written in the past year; the Aetna covers approximately 310 Iowa physicians.

Medical Protective: Mr. Roger Garner explained that Medical Protective experienced a small underwriting loss in 1975, but was able to add to its reserves. He indicated the company expects to remain active in states where it is writing business. He hopes and expects MP to continue its coverage at $200,000/$600,000 in Iowa, in contrast to

some states where limits have been reduced to $100,000/$300,000. He acknowledged that physicians written by MP may encounter difficulty finding acceptable excess coverage. He said MP covers approximately 1,100 Iowa doctors. He reported MP is accepting applications for coverage and is giving first consideration to those who are completing residencies and/or internships. The company is not restricting coverage based on risk classifications. Mr. Garner indicated MP has agreed to consider the Hartford nonrenewals on an individual basis.

St. Paul: Mr. Elwin Dietel and Mr. Ted Cajacob advised that St. Paul is accepting new physicians and has added 30 new insureds in 1976. This is in addition to 68 new doctors in 1975, making an approximate total of 1,380 in Iowa; this includes approximately 700 physicians at the University of Iowa. Except for anesthesiology, the St. Paul is writing $1 million excess over its $100,000/$300,000 basic limits. The coverage for anesthesiologists is limited to the $100,000/$300,000 basic policy. St. Paul expects to complete its conversion to claims-made coverage by June. The second-year claims-made premium will be charged to some insureds this year; it is not expected to exceed rate increments announced initially. The upward claim trend was cited by St. Paul as a basis for continued concern (56 new claims in 1974, 62 in 1975, and 18 through February of 1976). The St. Paul officials emphasized that while a market does exist, physicians and others concerned about the future should not be lulled into complacency.

Iowa Society of Anesthesiologists: D. L. Sweem, M.D., Jackson Ver Steeg, M.D., and Charles Hull, M.D., indicated a number of anesthesiologists have premiums coming due this summer. They report that few, if any, umbrella policies have been obtained since last October, consequently some anesthesiologists are working without excess coverage. These developments reportedly have caused some to withdraw from the specialty entirely and others have switched to lower risk practice classifications. The problem has been less acute among anesthesiologists associated with multi-specialty groups. With various policy renewals in the offing, it is hoped Insurance Commissioner Huff can locate acceptable coverages. Otherwise, according to the ISA representatives, Iowa may face a serious curtailment of anesthesia services.

Various methods have been discussed with the anesthesiologists to focus attention on the Iowa professional liability problem. Further legislative action is regarded as necessary and important by the Iowa Society of Anesthesiologists, which is coordinating its legislative action through the IMS. A recent letter from the ISA summarizing the anesthesiology situation was filed with members of the Iowa Senate. Other plans to dramatize the malpractice problem are in a tentative status.

STATUS OF LEGISLATION

The Committee's HANDBOOK report noted (1) the Society's educational efforts with respect to House File 803, (2) the activities of the Legislative Interim Study Committee, (3) the several legislative proposals advocated by the IMS, (4) the status of the Joint Underwriting Association, and (5) the consideration given to a state excess liability fund.

Certain further and significant legislative developments have occurred since the preparation of the HANDBOOK report and since the April 15 meeting of the Medico-Legal Committee. An oral briefing on recent actions of the Iowa General Assembly, and their potential impact, will be presented to the House of Delegates May 1 by the chairman of the Medico-Legal Committee and by Donald C. Young, M.D., chairman of the IMS Legislative Committee.

For purposes of background information, two professional liability bills have been introduced in the current session of the Iowa General Assembly—H.F. 1489 and S.F. 1310. Both bills contain provisions considered by the Legislative Interim Study Committee.

Senate File 1310 passed the Senate April 27 after two days of debate. The bill includes items supported by the Society—but these provisions unfortunately were amended to the extent they are now either highly questionable or totally unacceptable. The key features of Senate File 1310 include statutory reporting of malpractice by all health care providers, court review of lawyers' contingency fees only if requested by the client, and allowance for arbitration agreements on other than a binding basis. The amendment to place a $200,000 ceiling on noneconomic loss was defeated 24-25, and a provision to allow for periodic payments was ruled not germane. As it stands now, the Senate-passed bill is meaningless and offers little help for the malpractice dilemma which is having a definite impact on the cost of medical care. Iowa physicians must urge members of the House of Representatives to take corrective action on the bill, short of this it must be allowed to expire without final passage.

In addition to S.F. 1310, which will be directed to the House, the lower chamber has H.F. 1489 recommended for passage by its Commerce Committee. This measure provides for a $100,000 limit on non-economic loss (pain and suffering), arbitration of future medical disputes, increased disciplinary responsibility to the profession and the Board of Medical Examiners, and tightening of the contingency fee procedures adopted in 1975. This bill will be sidetracked with the House now giving consideration to the Senate-passed measure.

As this report is prepared, the legislative picture is unsettled. Prospects for further positive malpractice legislation are definitely clouded. It may be possible to present more definitive information when the House of Delegates is in session.

STATE EXCESS FUND

Because our most serious coverage problem exists with excess coverage, the Committee has chosen to elaborate briefly on the state fund concept. This approach has been investigated in some detail by the Society. The idea was shared with the Executive Council this year and received with only limited enthusiasm. The concept is acknowledged to have both virtues and pitfalls. Various plans of this type have been implemented in other states.

Under this approach state legislation would create what might be called the Iowa Patient/Physician Protection Fund. Provision would need to be made for a mechanism to specify what limit of private liability coverage a physician must carry. This could be $100,000/$300,000, or conceivably $200,000/$600,000. Iowa physicians would then fund the IPPPF by contributing a percentage of their primary coverage premium to the state fund. The fund would then become the source of payments for all awards which are in excess of the established primary limits.

As has been stated, the Society has conferred with various experts on this type of program. The reaction of those private insurance representatives with whom discussion has occurred has been essentially negative. The plan imposes the element of state control and the uncertainty which that carries. In order to function, the plan would presumably make physician participation compulsory.

The basic blueprint for a program of this type was shared with the Legislative Interim Study Committee. The general response was to avoid state involvement un-

less absolutely necessary. Regardless of these admonitions, which have even more meaning when legislative developments occur as they have the past few days, the approach must be considered as one alternative to a major and current dilemma. Thus, the idea is submitted for the consideration by the House of Delegates. More detailed information will be provided on request to the Reference Committee.

SUMMARY

The comments in this report, plus those in the HANDBOOK, and those oral remarks to be made on the current legislative picture, highlight what is believed to be a continued and careful consideration of the vexing professional liability problem. The Iowa situation remains better than many states and worse than others. It must be acknowledged that in the main there has been an improvement in the Iowa professional liability market in the past 12 months.

The following recommendations are submitted to the House of Delegates for consideration:

1. That the Society continue to seek effective state legislation to build on House File 803 with the goal of bringing equity and stability into the professional liability picture.
2. That the Society examine further the potential of and need for a State Excess Fund in accordance with any further expressed instructions from the House of Delegates.
3. That the Society continue to provide maximum available support to specialty groups hardest hit by the liability problem.
4. That the Society continue to investigate and pursue the possibility of a sponsored, group-type coverage with a reputable company.
5. That the Society continue to provide within its means informational and educational material on this subject to member physicians and their patients.
6. That the Society continue to gather and assimilate survey and research data upon which logical and defensible remedial measures can be based.

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SUBCOMMITTEE ON PUBLIC ASSISTANCE

(Referred to the Reference Committee on Articles of Incorporations and By-Laws and Legislation.)

The recent fiscal problems of the Iowa Medicaid Program were summarized in the HANDBOOK report of the Subcommittee on Public Assistance. In this Supplemental Report a further assessment is made of the Medicaid financial picture, particularly as it pertains to the coming year.

In the days remaining in this legislative session, the Iowa General Assembly must appropriate funds to continue the Medicaid Program. There is considerable interest in and speculation over the amount of this allocation. Most observers, in the Assembly, in the State Department of Social Services (SDSS) and elsewhere, are predicting the state appropriation will be in the neighborhood of $50 million. It has been estimated that at least $57 million will be needed to maintain Medicaid at its present level in the coming year. Herein lies the source of concern. How and where can reductions be imposed if the allocation is below the anticipated need?

To its credit, the Iowa General Assembly approved a $13.8 million supplemental appropriation earlier this year. This has allowed the program to maintain its existing scope of benefits. This action was urged by the Iowa Medical Society and all of the various vendor groups, individually, and through the Medical Assistance Advisory Council. It has been indicated that from $1.6 to $1.8 million of the supplemental appropriation may remain at the close of the fiscal year for possible carry over—if such authorization were given.

In addition to recommending a $50 million appropriation, the Joint Appropriation Subcommittee on Human Resources has indicated it may function as an interim committee to consult with the SDSS and the Medical Assistance Advisory Council. The thought has been expressed that the Assembly, the provider groups and the SDSS should work together to maintain the program. It is still possible that a consulting firm may be hired to evaluate the program and make recommendations.

The Medical Assistance Advisory Council has met five times in the months since Medicaid financing has become an acute matter. Much extensive statistical and fiscal information has been provided and discussed on these occasions. As most physicians are aware, and as the HANDBOOK report notes, the intermediate care facilities (ICF's) receive the major portion of the Medicaid funds. In the past three years, the ICF's have received between 51 and 52% of the appropriation; the other vendors share most of the balance. Physicians, as a vendor group, have continued to receive around 10% of the Medicaid allocation.

At its meeting on April 7, 1976, the Medical Assistance Advisory Council instructed the SDSS to meet separately with each vendor group to receive further cost curtailment ideas and to compile them into a composite plan. This plan was submitted to the Council on April 20, 1976. The haste was regarded as necessary in view of the General Assembly's impending consideration of a new appropriation.

Representatives of the Iowa Medical Society met with SDSS officials on April 15, 1976, to review once again the financial aspects of Medicaid insofar as physicians are concerned. In this meeting emphasis was placed on the anticipated ability of the Professional Standards Review Organization (PSRO), as an instrument of the medical profession, to assure that care provided under any of the federally-funded programs is appropriate and cost-effective. There is no way of knowing at this time what financial impact the PSRO will have on the Medicaid program. No dollar sum was even suggested. In addition, the Society has indicated that attention is being given, through its committee structure and the Iowa Psychiatric Society, to the evaluation of care criteria for mental health services. A committee of the IPS has been formed to undertake this updating effort and it will meet May 1. As a further indication of a willingness to keep physicians informed as to the financial circumstances of Medicaid and to increase the degree of cost consciousness, the Society indicated to the SDSS its communication mechanisms are available on an increased basis to inform physicians of the fiscal problems confronting Medicaid.

Out of the recommendations submitted by the vendors came a composite plan which was submitted to the Medical Assistance Advisory Council on April 20, 1976. When combined, the suggestions of the vendors were estimated to represent a potential state savings of $1.3 million. This

amount subtracted from the estimated need of $57 million produces a $55.7 million alternate sum. These and other figures were considered on April 20. Out of the deliberations came approval of a motion placing the Council on record as favoring a $54 million appropriation, with the possible addition of any carry-over from the current year (which, as mentioned previously, could amount to $1.5 to $1.8 million). This same motion included provision for implementation of the vendor cost containment measures represented in the $1.3 million mentioned above. Finally, in a third portion of the Council's action, approval was given to further cost containment measures suggested by the SDSS, pending further negotiations with the vendor groups involved. Included in this latter category from the physicians' standpoint were (1) "payment parameter of one office visit per month for a chronic condition," (2) "place an upper limit on surgical fees." The intent and impact of these recommendations have not been pursued with SDSS as yet.

While the Iowa Medical Society is by law a member of the Medical Assistance Advisory Council, and participates in its meetings, it is not bound individually by its actions. In this connection, the Society, throughout the recent Medicaid fiscal deliberations, has supported as strongly as possible an appropriation which allows the program to be maintained with (1) the present level of services, and (2) with the present level of reimbursement. As has been noted, the Medicaid reimbursement formula (same as Medicare) for physicians is tightly controlled and is markedly below the actual charges for the services provided.

Those Society representatives who have occasion to work with the governmental officials on these Medicaid matters expect to continue in the vein noted here and will welcome any endorsement or further instructions from the House of Delegates.

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Supplemental Reports of Special Committees

COMMITTEE ON DELIVERY OF HEALTH SERVICES

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

See bracketed portion of HANDBOOK FOR HOUSE OF DELEGATES *material published on page 274 of this issue of the* JOURNAL.

EYE CARE COMMITTEE

(Bracketed portion of this report referred to Reference Committee on Articles of Incorporation and By-Laws and Legislation. Balance of report referred to Reference Committee on Insurance and Medical Service.)

[Information brought to the Committee's attention indicates that the Iowa optometrists will almost certainly introduce a bill in the 1977 Iowa General Assembly seeking to permit the use of diagnostic drugs by optometrists. Such legislation has been introduced in many states and enacted in approximately nine. Fourteen additional states have optometric licensing laws which make no reference to this use of drugs, and it is understood that in most of these states the optometrists do use drugs. There are many reasons for opposing the use of drugs by optometrists, and the Committee is planning to formulate a paper to set forth these reasons in writing. The Committee unanimously recommends that the IMS House of Delegates adopt the following statements of policy:

1. The IMS opposes any legislation to permit the use of drugs for diagnostic or therapeutic purposes by optometrists.

2. The IMS believes that physicians in the practice of ophthalmology are and should remain primary physicians for eye care and that the IMS should actively resist any efforts to erode this concept.]

The Committee has, in consultation with officials of Blue Cross/Blue Shield, reviewed an indemnity vision

VISION CARE PROGRAM OUTLINE (BLUE CROSS-BLUE SHIELD OF IOWA)

I. Type of Certificate
   Amendment to Blue Shield Certificate
   May be offered to present and potential BC-BS subcsribers
II. Availability of Program
   A. Entire State of Iowa through BC-BS of Iowa and Blue Cross of Western Iowa
   B. Group Business—Any size of group
   C. H.I.A. Business—Subscribers under 65
   D. Left Employ—Subscribers under 65
III. Rating and Underwriting
   A. Community Rating
      1. Groups under 50 contracts
      2. H.I.A.
      3. Left employ
   B. Merit Rating
      Groups of 50 and over contracts
   C. Employer contribution levels
      Single contribution in group business
IV. Eligible Providers
   A. Duly licensed physician
   B. Duly licensed optometrist
   C. Dispensing optician
V. Payment Method
   A. Participating
      The maximum schedule of allowances will be paid directly to the provider. For those charges incurred by the subscriber for benefits in excess of scheduled allowance, the subscriber will assume the responsibility for the remaining liability.

B. Non-Participating

Payment will be made directly to the subscriber based on the maximum schedule of allowances. For those charges incurred by the subscriber for benefits in excess of scheduled allowance, the subscriber will assume the responsibility for the remaining liability.

VI. Quality Assurance

Pre and Post Payment Guidelines

Established by the Corporation's medical staff in consultation with the Medical Advisory Committee to include, but not limited to:

a. Quality of care
b. Frequency of care
c. Random sample audit
d. Provider review and analysis for Medical Advisory Committee

VII. Peer Review

A. Medical Advisory Committee
to
B. Provider Relations Committee
to
C. Blue Shield Board of Directors

VIII. Certificate Benefits

A. Eye examination or visual survey and analysis
1. Members under 19 years of age——Once per 12-month period
2. Members 19 years and older—Once per 24-month period

B. Lenses
1. Members under 19 years of age—Two lenses per 12-month period
2. Members 19 years and older—Two lenses per 24-month period

C. Frames
1. Members under 19 years of age—One per 12-month period
2. Members 19 years or older—One per 24-month period

D. Limitations/Exclusions
1. Benefits will be limited to payment for those services necessary to adequately correct the existing vision disorder.
2. No medical or surgical treatment of the eye (Covered by basic Blue Shield Certificate.)
3. No replacement of lost, stolen or broken lenses, contact lenses or frames.
4. No drugs or medications, even if prescribed.
5. No benefits for orthoptics, vision training, aniseikonic studies and prescriptions, reading problem studies or other procedures determined to be special or unusual.
6. Compensation for services/materials will be primarily based on medical necessity. (Guidelines to be formulated.)
7. Payment for lenses and/or frames shall be limited to those covered benefits itemized in "Maximum Schedule of Allowances."

IX. Maximum Schedule of Allowances

Blue Shield will pay up to the scheduled allowance for covered eye care benefits for a subscriber and/or dependent members.

Covered Benefits	*Maximum Allowance*
Comprehensive eye examination by physician	$20.00
Visual survey and analysis by optometrist	15.00
Single vision lens, each	10.00
Bifocal lens, each	18.00
Trifocal lens, each	20.00
Lenticular lens, each	40.00
Contact lens, each	20.00
Frames	20.00

X. Gross Monthly Rates

Estimated community rates for groups of 50 or less subscribers are:

Single . . . $1.90
Family . . . $4.90

DEFINITIONS VISION CARE

Comprehensive Eye Examination by Physician	A comprehensive medical eye examination rendered by a physician, including but not limited to, a diagnostic ophthalmologic examination, with refraction as medically indicated, initiation of treatment program, prescription of medication and lenses if indicated, post cycloplegic visit if required and verification of lenses if prescribed.
Vision Survey and Analysis by Optometrist	An examination including but not limited to case history, refraction, coordination measurements and tests, and prescription of lenses as needed and verification of lenses if prescribed.
Lenses	Ophthalmic corrective lenses ground as prescribed by a "Physician or Optometrist" to be fitted into a frame which meets the Prescription Standards and Tolerances of the American National Standards Institute.
Frame	A standard plastic eyeglass frame or frame of equal utility, into which two lenses are fitted.
Contact Lenses	Ophthalmic corrective lenses grounded as prescribed by a physician or Optometrist to be fitted directly to the patient's eyes which meet the Prescription Standards and Tolerances of the American National Standards Institute.
Physician, Ophthalmologist	A Doctor of Medicine (M.D.) or Osteopathy (D.O.), a physician licensed to practice medicine and surgery. An ophthalmologist is one who specializes in the diagnosis and treatment of diseases and defects of the eye. In treatment, the ophthalmologist prescribes medicine, glasses, contact lenses, prisms, exercises and other therapies and performs surgery.
Optometrist	A Doctor of Optometry (O.D.), a licensed, non-medical practitioner, who measures refractive errors—that is, irregularities in the size or shape of the eyeball or surface of the cornea—and eye muscle disturbances. In treatment, the optometrist prescribes glasses, contact lenses, prisms and exercises.
Optician	One who fits, adjusts and dispenses glasses, and other optical devices, on the written prescription of a licensed physician or optometrist.

care program. The proposed program has been evaluated item by item with several additions and deletions offered. The Committee conducted a detailed discussion of both the positive and negative factors in such a vision care program and recommends the proposed program for approval by the IMS House of Delegates (copy attached.)

One member of the Committee voted against further development of the program preferring a plan that provides comprehensive eye care coverage. The Committee agreed that it would suggest to Blue Cross/Blue Shield that a program be investigated which would provide coverage for physician services for eye care to fill the void between present Blue Cross/Blue Shield coverage and the proposed vision care program.

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E. M. SWANSON, M.D.
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AD HOC COMMITTEE ON 1976 NATIONAL SWINE VIRUS VACCINE PROGRAM

(Referred to the Reference Committee on Reports of Officers and Miscellaneous Business.)

The forthcoming nationwide program to immunize 210 million Americans against the swine-like flu virus has received wide notoriety in recent weeks. As reported in the media, the federal government has allocated $135 million to purchase vaccine for use by the individual states this summer and fall.

The consideration of an Iowa Program has been in process for more than a month. In this connection, President V. L. Schlaser, M.D., has appointed a special Society committee to confer with officials of the State Department of Health to determine what approach will attain optimal coverage in Iowa in the time available.

The special IMS committee has met twice. In addition its chairman has attended a conference at the Center for Disease Control in Atlanta, Georgia, with officials of the Department of Health. A progress report from the Committee was presented to the IMS Executive Council on April 6. At that time the Council endorsed the participation of private medicine in this project and requested the House of Delegates be provided with more detailed information as to how the program is planned for implementation in Iowa.

This supplemental report is submitted in an attempt to comply with the request of the Executive Council. The Committee is including with its report a blueprint or plan which has been devised with input from the Department of Health plus that of various health care providers in Iowa, including the Medical Society, the Iowa Society of Osteopathic Physicians and Surgeons, the Iowa Academy of Family Practice, and the Iowa Chapter, American Academy of Pediatrics.

It is perhaps important to note that an endorsement of the national program has been issued by the American Medical Association. Following is the brief statement issued by the AMA on March 26, 1976:

"The American Medical Association supports the decision of President Ford to undertake a massive national immunization campaign against the swine-like influenza virus. Under the circumstances, we believe his decision is absolutely the correct one.

"The AMA stands ready to assist in the national campaign in any way possible, including organizing the medical profession to insure that every person who wants to be vaccinated will be—regardless of ability to pay.

"We speak for the medical profession in committing the doctors of this nation to make whatever efforts are necessary to vaccinate the entire population. It will not be easy, but it can and must be done."

With the preceding statement representing the national posture of the medical profession, and acknowledging that some scientific, logistic and economic questions remain to be fully resolved, the Committee believes nonetheless that individual physicians and county medical societies should give attention to the blueprint recommended for Iowa. The Committee believes further the plan should be (1) implemented as is, or (2) adapted locally to more effectively serve the county or community in question.

In the planning which has occurred to date, it is appropriate to acknowledge the guidance and cooperation which has been provided by officials of the State Department of Health, particularly Commissioner Norman Pawlewski and Jim Thompson, the Director of the SDH Immunizations Program.

The attention of the House of Delegates is directed to the attached plan. In view of the limited time which is available, certain aspects of the plan are now in process. It is the intention of the Committee to continue to work with the Department to promulgate the plan and to assist to the extent possible in its successful implementation. The Committee urges endorsement of the plan and the entire program by the 1976 Iowa Medical Society House of Delegates.

J. F. VEVERKA, M.D., *Chairman*
J. M. WALL, M.D.
D. J. WALTER, M.D.

Iowa Swine Influenza Immunization Plan

INTRODUCTION AND GOAL

This intensified immunization effort will have as its goal the prevention of morbidity and mortality from influenza in Iowa during winter 1976-77. The participation and cooperation of many individuals (particularly Iowa physicians) and organizations (including the Iowa Medical Society) will be needed to achieve the goal.

The project is planned as a three-phase, highly-visible effort combining the time, expertise and facilities of individuals and agencies from both the private and public health sectors. A prephase segment of the plan will be undertaken to reach that portion of the population which is aged and/or chronically ill.

The plan described here will be presented to appropriate health officials (including those of the county medical society) in each county by representatives of the State Department of Health. It will be the intention of the SDH representatives to outline the plan, offer assistance as desired, and become familiar with any alternate approaches which may be devised locally. The chairman and members of the special committee of the Iowa Medical Society will make themselves available as possible to provide requested medical expertise.

PREPHASE (BIVALENT VACCINE)

It is expected that between 300,000 and 350,000 doses of bivalent vaccine (A Victoria and A Swine) will be available in Iowa by mid-July. This will be administered to aged and debilitated persons. Through the cooperation of the Health Facilities Association of Iowa and other agen-

cies, the residents of nursing homes and other congregate living facilities for the elderly will be immunized with this vaccine; there are about 37,000 individuals in this category.

The method of vaccine distribution, as it will be in Phase One, calls for the SDH to provide a supply to the pharmacies of all Iowa hospitals. From there, private physicians may obtain, themselves or by their authorized representatives, the amount of vaccine they anticipate they will need to provide coverage for the aged or ill under their care.

The determination as to who will receive this bivalent vaccine, outside of the residents of nursing homes, will be left essentially to physicians. This advance program will not be advertised as being available to the general public. More complete details on the prephase segment of the program will be set forth in a letter from the SDH to physicians, operators of health care facilities, etc.

PHASE ONE (THE PRIVATE SECTOR)

Two shipments of monovalent vaccine are expected to reach Iowa in August totalling approximately 2.5 million doses. The distribution of this vaccine by the SDH also will be to the pharmacies of Iowa hospitals.

The first target group to be vaccinated with this supply will include those in the health care field and those in other essential community services.

Next, it is hoped the major thrust of Phase One will proceed with the providers of health care (receiving leadership and direction from the county medical societies) mobilizing to provide a highly-concentrated, highly visible opportunity for residents of a county to become vaccinated. It is hoped and recommended that the date of Saturday, September 11, 1976, be used by physicians to initiate or offer entirely a significant private sector vaccination effort.

Each county will need to decide the exact manner in which it desires to conduct the private or Phase One element of the total program. In many instances, hopefully, the election will be made by physicians and clinics to open their facilities on the particular day (September 11) and/or other days selected to administer the vaccine to all regular patients and to others who appear to obtain protection in this manner. In some counties or communities, a determination may be made to conduct this phase at one or more hospitals or in some other appropriate community facility.

While SDH officials and others will be available to assist and counsel in this Phase One effort, the private sector will be largely responsible for its planning and execution. Now being organized is a coordinated program involving the Iowa Medical Society Auxiliary (and its osteopathic counterpart), the Iowa Federation of Women and the Jaycees. It will be the purpose of this program to obtain names of volunteer nurses and other health care and clerical personnel and arrange for their presence at local sites where their services are needed.

Use of the September 11 date by the local medical community will benefit from any statewide publicity which is issued. However, if for good reason, another date or dates are selected, assistance will be provided by the SDH in publicizing those special private sector efforts arranged by a particular county.

PHASE TWO (THE PUBLIC EFFORT)

Subsequent to the concentrated private effort (presumably in the concluding weeks of September), the public health resources of the SDH and those at the community level will offer swine-like influenza vaccine through schools, other institutional settings, public health clinics and in other prudent ways. It is expected that 10 qualified two-man jet injector teams from the SDH will assist local personnel in the seven most populated areas, i.e., Des Moines, Davenport, Sioux City, Cedar Rapids, Waterloo, Council Bluffs and Dubuque. The 450 school nurses and 225 public health nurses will supplement this effort in these and the remaining 92 counties.

In conjunction with the school and institutional aspects of Phase Two, it is expected that Sunday public immunization clinics will be conducted on September 19 and 26 in at least five locations in the Des Moines area and one each in the remaining six metropolitan areas. Additional Sunday clinics may be undertaken in the remaining counties depending upon the need and desires of local officials. It is obvious that support, advice and personal participation will be required of some physicians in the public or Phase Two portion of the campaign. An assessment of the state situation will be made in the last few days of September to determine the magnitude and direction of Phase Three.

PHASE THREE (CLEAN-UP EFFORT).

The month of October will be devoted to reaching by whatever means are decided those individuals who remain unvaccinated. In their offices and clinics, physicians may wish to remind patients of the need for the vaccination by a sign, a mailing, etc., and allow specific times during the month for the administration of vaccine to persons requesting it. Obviously, the vaccine will be available to physicians all through September and October for this purpose.

SDH personnel will continue to be available through October to work with and assist those counties and communities that wish and need to raise their immunization levels. It is hoped that by the end of October and the onset of the flu season a major portion of the state's population will be protected.

MATTER OF ECONOMICS AND INFORMATION REPORTING

The question of payment for the vaccine and its administration is a difficult one in the instance of this unique program. The manner has been discussed at length on several occasions. At this point, the hope is that uniformity may prevail so that individuals will participate on the same basis regardless of where and when they obtain the vaccination.

To this end, it is recommended that a one dollar donation be requested for each individual immunized, but that no person be turned away for inability to donate one dollar. In instances where private physicians, individually or banded together, give the vaccinations, the one dollar donation will be retained to help defray the cost of materials and the payment of personnel where this is necessary. One dollar donations received at the public clinics will be transferred to the state treasury to help offset a possible special state appropriation provided to meet state expenses. Any balance will probably be returned to the state fund.

When obtaining the vaccine physicians will be required to certify to two things: first, that they will make no charge for the vaccine itself, and second, that they will report by age category the individuals to whom the vaccine is administered. The SDH expects to have forms available which will facilitate these requirements.

It is recognized that physician charges for the administration of the vaccine will be for individual determina-

tion. The recommendation of a one dollar donation is offered for consideration by physicians and county medical societies in the interest of (1) uniformity and (2) the beneficial reflection it will have on the medical profession. We urge its acceptance.

SCIENTIFIC ASPECTS OF THE PROGRAM

The development and testing of the vaccine is now in process. Maximum effort is being made by the CDC and other branches of the federal government and the pharmaceutical industry to produce an effective and safe vaccine. The anticipated reaction rate has been estimated between 5 and 15%, with the majority of these restricted to a brief sore arm. Specific questions of a scientific nature may be directed to either the State Department of Health or the special committee of the Iowa Medical Society.

The subject of liability is being studied and it is possible this important element may be assumed by the state or handled in some special manner. It is well for the medical profession to know that the subject has been raised and is before state officials.

SUMMARY

Without mass immunization, government scientists warn, the nation runs a fair risk of enduring a "swine flu" pandemic several times greater than any flu outbreak in generations. Few people under 50 years of age have any natural antibodies and the population is nearly universally susceptible. Against this kind of backdrop, the special IMS Committee on the National Swine Virus Vaccination Program believes the Iowa medical profession must be willing to contribute the time and knowledge necessary to safeguard the population to the fullest extent possible.

RESOLUTIONS

SCOTT COUNTY MEDICAL SOCIETY
NO. 1 SCHOOL PHYSICAL EXAMINATIONS

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

WHEREAS, Physical examination forms signed by other than licensed medical doctors or osteopathic physicians and surgeons are being accepted by some school districts in Iowa; and

WHEREAS, Physical examinations given by medical doctors or osteopathic physicians and surgeons, or under their appropriate medical supervision, are the only examinations which can detect physical or medical problems; and

WHEREAS, Examinations given by such competent medical personnel would also assure adequate immunizations of our school age children, therefore be it

Resolved, That the Iowa Medical Society exert all its influence to encourage or require that physical examinations of children for school purposes be performed only by licensed medical doctors or osteopathic physicians and surgeons or under their appropriate medical supervision.

CERRO GORDO COUNTY MEDICAL SOCIETY
NO. 2 EMERGENCY MEDICAL SERVICES

(Referred to Reference Committee on Articles of Incorporation and By-Laws and Legislation.)

WHEREAS, A current major health problem in the State of Iowa is that group of illnesses which require emergency medical services, of which accidental injury and acute heart disease are the leading causes, therefore be it

Resolved, That members of the Iowa Medical Society assume responsibility for active leadership in their local communities and surrounding areas for the development of effective care for patients who require emergency medical services, particularly in the pre-hospital and early hospital phases of care, and be it further

Resolved, That the Iowa Medical Society apprise the political leadership at all levels in our State of the need for financial and legislative support for the development of Emergency Medical Services programs.

DUBUQUE COUNTY MEDICAL SOCIETY
NO. 3 PHYSICIAN REPRESENTATION IN HSA

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

WHEREAS, The Health System Agency is a bureaucratic reality; and

WHEREAS, The Health System Agency, by its nature, makes local health service ingenuity practically impossible to implement; and

WHEREAS, The Health System Agency is designed to minimize physician participation, therefore be it

Resolved, That the Iowa Medical Society work vigorously to assure physicians as provider representatives from every subarea to the state health system area board of directors and take collective action if this is not accomplished.

DUBUQUE COUNTY MEDICAL SOCIETY
NO. 4 PUBLIC INFORMATION RE MEDICAL MALPRACTICE

(Referred to Reference Committee on Articles of Incorporation and By-Laws and Legislation.)

WHEREAS, There is a need for the public to be better informed regarding its personal stake in the medical malpractice issue; there is inadequate information available to the general public regarding the physicians' viewpoint on medical malpractice, therefore be it

Resolved, That the Iowa Medical Society run a paid advertisement in the newspapers in the State of Iowa stating the physicians' views and their solutions regarding medical malpractice, and that these advertisements appear periodically.

DUBUQUE COUNTY MEDICAL SOCIETY
NO. 5 SUPERVISION OF PHYSICIAN'S ASSISTANT

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

WHEREAS, The Iowa Medical Society reaffirms the support of the physician's assistant as an extender of health services, and wishes to utilize the physician's assistant in the delivery of primary care without diminishing the quality of care, therefore be it

Resolved, That the duties of the physician's assistant be performed under the direct personal supervision of a physician; direct personal supervision meaning that the supervising physician be physically located on the premises where the services are being provided.

STORY COUNTY MEDICAL SOCIETY
NO. 6 EMERGENCY MEDICAL SERVICES

(Referred to Reference Committee on Articles of Incorporation and By-Laws and Legislation.)

WHEREAS, A major health problem in the State of Iowa is that group of illnesses which require emergency medical services, of which accidental injury and acute heart disease are the leading causes; and

WHEREAS, In our state there is general unawareness of this problem among many health providers as well as consumers and political leaders; and

WHEREAS, In Iowa, development of Emergency Medical Services to cope with this group of illnesses needs increasing attention and support by the medical community, therefore be it

Resolved, That members of the Iowa Medical Society assume responsibility for active leadership in their local communities and surrounding areas for the development of effective care for patients who require emergency medical services, particularly in the pre-hospital and early hospital phases of care, and be it further

Resolved, That the Iowa Medical Society apprise the political leadership at all levels in our state of the need for financial and legislative support for the development of Emergency Medical Services programs.

BOONE COUNTY MEDICAL SOCIETY
NO. 7 TITLE XIX FUNDING

(Referred to Reference Committee on Articles of Incorporation and By-Laws and Legislation.)

WHEREAS, The recipients of Title XIX medical care are being discriminated against because the program is not adequately financed, and

WHEREAS, Doctors in many areas are refusing to see Title XIX patients because of the economic loss due to underfinancing by the state government, and

WHEREAS, Other doctors are often overburdened by these Title XIX patients when they will see them and suffer even greater economic loss, therefore be it

Resolved, That the Iowa Medical Society, as a unit, refuse to render care to Title XIX patients except on an emergency basis until the state legislature revises the law to pay usual and customary fees for all Title XIX recipients and adequately appropriate monies to cover this program.

DUBUQUE COUNTY MEDICAL SOCIETY
NO. 8 MALPRACTICE

(Referred to Reference Committee on Articles of Incorporation and By-Laws and Legislation.)

WHEREAS, The malpractice situation is becoming serious, and

WHEREAS, The increasing number of nuisance suits without merit is aggravating the situation, therefore be it

Resolved, That the Iowa Medical Society study the plan of the Illinois State Medical Society to counteract and counter sue malpractice suits without merit and determine its application in the State of Iowa.

POLK COUNTY MEDICAL SOCIETY
NO. 9 EMERGENCY MEDICAL SERVICE

(Referred to Reference Committee on Articles of Incorporation and By-Laws and Legislation.)

WHEREAS, A major current health problem in the State of Iowa is that group of illnesses which require emergency medical services, of which accidental injury and acute heart disease are the leading causes, and

WHEREAS, In our state there is general unawareness of this problem among many health providers as well as consumers and political leaders, and

WHEREAS, In Iowa development of emergency medical services to cope with this group of illnesses lags far behind the national trend in this area of health care delivery, therefore be it

Resolved, That members of the Iowa Medical Society assume responsibility for active leadership in their local communities and surrounding areas for the development of effective care for patients who require emergency medical services, particularly in the pre-hospital and early hospital phases of care, and be it further

Resolved, That the Iowa Medical Society acquaint the political leadership at all levels in our state of the need for financial and legislative support for the development of emergency medical services programs.

POLK COUNTY MEDICAL SOCIETY
NO. 10 UNIFIED MEMBERSHIP

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

WHEREAS, It is imperative that the medical profession present a strong and effective voice at all levels of its involvement, and

WHEREAS, Broad participation by members of the medical profession is absolutely necessary if such an objective is to be achieved, and

WHEREAS, Several states have successfully instigated a provision which requires membership in all components of organized medicine (county, state and national), therefore be it

Resolved, That the concept of unified membership be considered for establishment in the State of Iowa.

POLK COUNTY MEDICAL SOCIETY
NO. 11 CUSTOMARY FEE UPDATE

(Referred to Reference Committee on Insurance and Medical Service.)

WHEREAS, Blue Shield of Iowa updates its usual fee charges twice a year, and

WHEREAS, Iowa physicians are now experiencing severe inflationary conditions, therefore be it

Resolved, That the Iowa Medical Society urge Blue Shield of Iowa to update its customary charge profile twice a year.

DUBUQUE COUNTY MEDICAL SOCIETY
NO. 12 MALPRACTICE

(Referred to Reference Committee on Articles of Incorporation and By-Laws and Legislation.)

WHEREAS, Malpractice rates have risen tremendously in the past several years, and

WHEREAS, This in turn represents an increased burden to patients being treated, and

WHEREAS, With this added encumbrance on physicians (in particular new physicians starting practice), they are forced to withdraw or not to begin practice in the first place; therefore be it

Resolved, That legislation be enacted requiring public disclosure by the insurance industry of all malpractice liability claims made and paid for.

DUBUQUE COUNTY MEDICAL SOCIETY
NO. 13 DISASTER SUPPORT SYSTEM

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

WHEREAS, The recent earthquake disaster in Guatemala produced tremendous loss of life and even greater numbers of injured people with the obvious pain and suffering accompanying such a disaster, and

WHEREAS, The national organization, i.e., American Medical Association, does not have a national disaster program that would allow physicians to be sent on a volunteer basis to areas of need in this hemisphere; therefore be it

Resolved, That a plan for developing a disaster support system of physicians on a volunteer basis be developed. They could be transported by the United States Air Force on a 24-hour notice to any place in North and South America for disaster relief.

CHEROKEE COUNTY MEDICAL SOCIETY
NO. 14 MULTIPHASIC HEALTH TESTING PROGRAMS IN IOWA

(Referred to Reference Committee on Insurance and Medical Service.)

WHEREAS, Several multiphasic health testing programs are operating in Iowa, including American Health Profiles, Inc. and International Compumedics Corporation; and

WHEREAS, These programs are not complying with the guidelines established by the House of Delegates of the AMA, December, 1971 as reported by the Council on Medical Service, Report C; and

WHEREAS, Physicians are not involved in the planning and development of the testing programs; and

WHEREAS, The programs are not being supervised by qualified physicians at the testing center; and

WHEREAS, The reliability and quality control utilized by the testing programs are unknown; and

WHEREAS, There is serious doubt that these programs are operating legally under the laws of the State of Iowa which require direction by an Iowa-licensed physician; and

WHEREAS, Some of the tests, such as the "papette," are worthless and may actually be dangerous because of producing a false sense of security; and

WHEREAS, These programs have failed to contact the local medical societies to explain their programs prior to operation in their areas; and

WHEREAS, Interpretation of the tests performed or failure to do so exposes the attending physician to increased medical liability; therefore be it

Resolved, That the Iowa Medical Society be opposed to any multiphasic health testing programs operating in the State of Iowa until such time as they have demonstrated: (1) Reliability of services and quality control; (2) Medical direction by an Iowa-licensed physician; (3) Willingness to seek approval by the local county medical society *before* operation in that area; (4) Legality of operation as determined by the Iowa State Board of Medical Examiners and be it further

Resolved, That if legal opinion is not forthcoming from the State Attorney General's office, as requested by the Iowa Board of Medical Examiners, that legal suit be instituted by the Iowa Medical Society to determine the legality of such programs.

BLACK HAWK COUNTY MEDICAL SOCIETY
NO. 15 MALPRACTICE LEGISLATION

(Referred to Reference Committee on Articles of Incorporation and By-Laws and Legislation.)

WHEREAS, The State of Iowa has lost physicians from the practice of medicine due to the rising cost of medical liability insurance, and

WHEREAS, The State of Iowa has even greater potential to lose physicians from the practice of medicine for the same reason, and

WHEREAS, The State of Iowa has been severely hampered in recruiting new physicians into this state for the same reason, and

WHEREAS, The rising cost of medical liability insurance premiums will cause the complete collapse and cessation of special high risk services such as Neonatal Intensive Care Centers in our state, and

WHEREAS, More and more physicians in Iowa will be able to offer fewer and fewer services, thereby further limiting physician services which are already in short supply, and

WHEREAS, Legislation presently before the Iowa Legislature is being reduced and weakened to the point where it will be absolutely ineffective in holding down or lowering medical liability insurance rates, and

WHEREAS, States surrounding Iowa or close neighbors to Iowa have enacted legislation that has substantially aided in controlling or reducing premiums for medical liability insurance; therefore be it

Resolved, That the Iowa Medical Society continue to promote current legislation before the Iowa Legislature which offers some hope of reducing costs of medical liability insurance and further concentrate all its energies beginning now and carrying into the next session of the Iowa Legislature towards support of legislation known to be effective in reducing insurance costs using the Indiana Malpractice Bill as a model.

POLK COUNTY MEDICAL SOCIETY
NO. 16 TRIBUTE TO HERMAN J. SMITH, M.D.

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

WHEREAS, The medical profession in Iowa received distinguished and extensive leadership from Herman J. Smith, M.D., Des Moines, and

WHEREAS, This leadership exemplified itself in positions of responsibility within the Polk County Medical Society, the Iowa Medical Society and the American Medical Association, and

WHEREAS, Through his abilities and interests in the transmission of medical knowledge, many Iowa practitioners and medical students have become better physicians; therefore be it

Resolved, That the Iowa Medical Society honor Herman J. Smith, M.D., by designating a special presentation at each annual Scientific Session in his memory.

WRIGHT COUNTY MEDICAL SOCIETY
NO. 17 BLUE SHIELD UCR FEE PROFILES

(Referred to Reference Committee on Insurance and Medical Service.)

WHEREAS, The rural areas of Iowa in general (in our county, in particular) are having increasing difficulty obtaining physicians to serve these equally-important residents.

WHEREAS, The average young doctor going into practice is already in major debt.

WHEREAS, Discrimination of double and triple fee sched-

ule standards to rural physicians doing identically the same procedures as urban physicians are vastly different and lower, thereby resulting in a marked lack of incentive for young physicians to practice in rural Iowa.

WHEREAS, The State of Minnesota has resolved this well with a plan which designates the same fee to all qualified physicians doing the same procedure (whether or not they are based in Minneapolis or International Falls).

WHEREAS, Blue Shield is inadvertently becoming the single most deterrent for our recruitment of rural low-populated areas in Iowa in recruiting physicians; therefore be it

Resolved, That the Board of Directors of Blue Shield be given a strong suggestion from this legislative body of this Iowa Medical Society, that Blue Shield should cease its double-triple screen standards in fee-for-procedure for all physicians in UCR. That further, the single fee screen for procedure used by Minnesota Blue Shield* so successfully at this time be adopted by its Iowa counterpart.

*(Minnesota Blue Shield started a single screen for UCR. It was implemented 7/1/75: "Traditionally, profiles have been established according to historical recording of what physicians actually charged, broken down by various specialty and geographic areas. With the single screen, a service performed by any physician competent to do that service will receive the same reimbursement, regardless of his specialty.") *From 4/14/76 letter to all Minnesota physicians, by J. Q. Regnier, Acting President, Minnesota Blue Shield.*

IDA COUNTY MEDICAL SOCIETY
NO. 18 PROFESSIONAL LIABILITY

(Referred to Reference Committee on Articles of Incorporation and By-Laws and Legislation.)

WHEREAS, The cost and restrictions on casualty insurance are becoming prohibitive, and

WHEREAS, The practice of medicine is not an exact science and contains many elements of an art, and

WHEREAS, It is the duty of the medical schools to graduate only those persons who are well qualified, and the duty of the licensing boards to license only those who are well qualified, and

WHEREAS, The personal relationship between patient and physician, freely applied for and freely given, should not be interfered with; therefore be it

Resolved, That it shall be reasonable and proper to require all patients to read and sign a form stating the physician's position and requiring the patient's acceptance of this condition to be accepted as a patient. Ideal results may not be obtainable and must be accepted by the patient. Only gross negligence or abandonment should be considered as grounds for a suit against a physician in the practice of his profession.

SCOTT COUNTY MEDICAL SOCIETY
NO. 19 MALPRACTICE

(Referred to Reference Committee on Articles of Incorporation and By-Laws and Legislation.)

WHEREAS, Malpractice is the issue that "bugs" physicians most these days and arouses their emotions, and

WHEREAS, Physicians cannot realistically expect the Iowa Legislature and the insurance industry to be keenly motivated in their behalf, and

WHEREAS, Tradition indicates that "help comes most abundantly to those who help themselves"; therefore be it

Resolved, That a most aggressive approach be taken by the Iowa Medical Society to resolve malpractice problems in Iowa, i.e., (1) review every Iowa malpractice case that has gone to trial within the past two years, excluding cases where the physician has lost or settled; (2) review carefully the remainder and select those cases where judgments were consistently in favor of the physician defendant; (3) then select one case to be used as a countersuit by the Iowa Medical Society on behalf of the physician involved.

POLK COUNTY MEDICAL SOCIETY
NO. 20 OFFICE OVERHEAD REIMBURSEMENT

(Referred to Reference Committee on Insurance and Medical Service.)

WHEREAS, Blue Shield of Iowa now pays hospital charges for professional services performed on out-patients, and

WHEREAS, Iowa physicians are experiencing a spiraling rise in office overhead; therefore be it

Resolved, That Blue Shield of Iowa extend coverage, in addition to professional fee charges, to include office overhead charges identical to as if the service were performed in the hospital or its out-patient department.

LIFE AND ASSOCIATE MEMBERSHIPS

LIFE MEMBERSHIPS RECOMMENDED ON THE BASIS OF 50 YEARS' PRACTICE AND THE LAST 15 CONSECUTIVE YEARS' MEMBERSHIP

County	Name
Bremer	Herbert W. Rathe, M.D., Waverly
Jasper	Edward A. McMurray, M.D., Kellogg
Lee	Harry D. Harper, M.D., Fort Madison
Linn	Francis C. Dunn, M.D., Cedar Rapids
Wapello	DeVoe O. Bovenmyer, M.D., Ottumwa
Webster	Otto N. Glesne, M.D., Fort Dodge
Woodbury	Joseph M. Krigsten, M.D., Sioux City

The physicians nominated for each of these membership categories were approved unanimously.

The Speaker advised the delegates of the time and locations of the several reference committee hearings. It was explained the House would reconvene at 8:30 a.m. on Sunday, May 2, 1976, and voting would begin at 7:30 a.m. The opening session was adjourned at 1:10 p.m.

ASSOCIATE MEMBERSHIPS RECOMMENDED ON THE BASIS OF RETIREMENT OR INCAPACITATION

County	Name
Black Hawk	Russell W. Blanchard, M.D., Pinellas Park, Fla.
	Clarence J. Mikelson, M.D., Waterloo
Cerro Gordo	Lindsay J. Kirkham, M.D., Clear Lake
	James W. Lannon, M.D., Mason City
Cherokee	Daniel J. Sheehan, M.D., Cherokee
Clinton	May Danielson, M.D., Clinton
	Ross C. King, M.D., Clinton
Dallas-Guthrie	LaVerne Utterback, D.O., Clear Lake
Davis	Paul T. Meyers, M.D., Bloomfield
Hardin	Emerson J. Steenrod, M.D., Iowa Falls
Harrison	Albin C. Bergstrom, M.D., Missouri Valley
Henry	Wayne B. Brown, M.D., Mount Pleasant
	Byron D. Hartley, M.D., Mount Pleasant
Humboldt	Asa S. Arent, M.D., Humboldt
Jefferson	Frank H. McClurg, M.D., Fairfield
Johnson	Alson E. Braley, M.D., Iowa City
	Lorraine H. Frost, M.D., Iowa City
	Albert P. McKee, M.D., Edgemont, Ark.
	Adolph L. Sahs, M.D., Iowa City
Lee	Arthur C. Richmond, M.D., Fort Madison
Linn	William G. Kruckenberg, M.D., Cedar Rapids
	William H. Middleton, M.D., Cedar Rapids
	Robert M. Wray, M.D., Cedar Rapids
Plymouth	Roman J. Fisch, M.D., LeMars
	Laurence C. O'Toole, M.D., LeMars
Sioux	Alexander Bushmer, M.D., Orange City
Webster	Charles H. Coughlan, M.D., Fort Dodge

SUNDAY SESSION, MAY 2, 1976

The Sunday session of the House of Delegates was called to order at 8:30 a.m. The House approved the taking of attendance by registration cards. There were 105 delegates, 16 voting alternates and 16 ex-officio members present. Delegates were provided reference committee reports and ballots at the time of registration.

COUNTY	DELEGATE
Appanoose	A. S. Owca
Black Hawk	C. D. Ellyson
	R. S. Gerard
	R. T. Guthrie
	W. M. Kelly
	A. M. Dolan*
	S. D. Bovenmyer*
Boone	E. E. Linder
Bremer	G. J. Kimball
Buchanan	P. J. Leehey
Buena Vista	T. E. Shea
Cerro Gordo	W. G. Garrett
	R. E. McCoy
	R. M. Powell
	W. C. Rosenfeld
	D. D. Van Etten
Cherokee	G. E. Michel
Chickasaw	J. C. Carr*
Clay	J. X. Tamisiea
Clayton	J. D. Compton
Clinton	G. T. Schmunk
Crawford	D. J. Soll
Dallas-Guthrie	N. L. Krueger
	E. E. Lister
Davis	H. M. Perry
Decatur-Ringgold	D. E. Mitchell
Delaware	J. E. Tyrrell
Des Moines-Louisa	K. A. Hahn
	R. J. Rettenmaier
	J. P. Stoikovic
Dickinson	D. F. Rodawig, Jr.
Dubuque	J. S. Chapman
	K. K. Hazlet
	R. T. Melgaard
	J. W. White
Fremont	F. M. Ashler
Hamilton	G. A. Paschal
Hancock-Winnebago	L. R. Fuller
Hardin	T. C. Graham
Harrison	J. W. Barnes
Humboldt	J. H. Coddington
Ida	J. B. Dressler
Jackson	J. A. Broman
Jasper	K. P. Petersen*
Jefferson	T. J. Sutton
Johnson	R. C. Brown
	K. D. Dolan
	S. W. Greenwald
	C. E. Hartford
	K. J. Judiesch
	K. J. Printen
	C. E. Radcliffe
	R. D. Whinery
Jones	A. P. Randolph
Kossuth	J. M. Rooney
Lee	J. E. McGee
	G. C. McGinnis
	R. L. Kent*
Linn	R. J. Barry
	J. H. Lohnes
	T. J. McIntosh
	R. A. Sautter
	G. R. Wessel
Mahaska	S. A. Smith
Marion	J. M. Dockum, D.O.*
Marshall	L. O. Goodman
	R. R. Widner
	J. W. Hughes*
Mitchell	R. G. Boeke
Monona	J. L. Garred
Muscatine	K. E. Wilcox
O'Brien	R. L. Zoutendam
Page	J. R. Gambill
Plymouth	J. P. Trotzig
Pocahontas	J. M. Rhodes, Sr.
Polk	Lester Beachy
	D. B. Dorner
	J. L. Fatland
	John Hess, Jr.
	J. I. Hostetter
	J. W. Olds
	L. J. Plummer
	R. C. Smith
	D. C. Young
	G. B. Purnell
	M. H. Dubansky
	C. H. Denser, Jr.*
	L. O. Ely*
	J. C. Bardole*
	B. T. Woodburn*
	D. J. Walter*
Pottawattamie-Mills	R. K. Fryzek
	J. L. Knott
	E. B. Mathiasen
	M. E. Olsen
	L. L. Leibel*
Scott	J. C. Barker
	Gordon Cherwitz
	W. B. Hofmann
	R. J. Ketelaar
	D. L. Miller
	R. M. Perkins, III
	F. W. Smith
Sioux	E. B. Grossmann, Jr.
Story	W. A. Baird
	W. R. Bliss
	Charles Jons
Tama	A. J. Havlik
Union-Taylor	R. H. Kuhl
Wapello	K. E. Lister
Winneshiek	Leonard Lamberty
Woodbury	J. S. Pennepacker
	D. M. Youngblade
	W. M. Krigsten*
	J. M. Krigsten*
Worth	B. H. Osten
Wright	A. F. Benetti
Student IMS	D. C. Trost
	James Dennert*

* Alternate

LIAISON DELEGATES

C. W. Seibert — J. D. Ver Steeg

EX-OFFICIO MEMBERS OF THE HOUSE

V. L. Schlaser	L. W. Swanson
J. F. Bishop	C. E. Radcliffe
J. H. Kelley	Erling Larson, Jr.
Hormoz Rassekh	J. R. Anderson
C. L. Kelly, Jr.	J. R. Scheibe
W. V. Wulfekuhler	R. L. Wicks
A. L. Sciortino	J. W. Eckstein
L. D. Caraway	J. H. Sunderbruch

Dr. Bliss read the minutes of the May 1 meeting of the House of Delegates and the House approved them.

The election of officers occurred and the following physicians were chosen:

President-elect	Leslie W. Swanson, M.D., Mason City
Vice-President	Alexander W. Boone, M.D., Davenport
Trustee (3 year term)	A. J. Havlik, M.D., Tama
Speaker of the House	Lynn D. Caraway, M.D., Amana
Vice Speaker of the House	John H. Lohnes, M.D., Cedar Rapids
Delegates to AMA (2 year term)	Erling Larson, Jr., M.D., Davenport John M. Rhodes, M.D., Pocahontas
Delegate to AMA (To fill unexpired 1-year term)	John Anderson, M.D., Boone
Alternate Delegates to AMA (2 year term)	Clarence H. Denser, Jr., M..D,, Des Moines Robert D. Whinery, M.D., Iowa City
Blue Shield Liaison Delegates to IMS	Cecil W. Seibert, M.D., Waterloo Jackson D. Ver Steeg, M.D., Des Moines
Councilor, District 1	Clarkson L. Kelly, M.D., Charles City
Councilor, District 4	Daniel M. Youngblade, M.D., Sioux City
Councilor, District 6	Albert M. Dolan, M.D., Waterloo
Councilor, District 11	Arthur L. Sciortino, M.D., Council Bluffs

Dr. Caraway thanked the members of the Reference Committee and asked delegates desiring to serve in this important capacity, to direct their inquiries to the Speaker, IMS Headquarters. He then informed the delegates of the proper procedure for debate and voting on the Reference Committee Reports.

REFERENCE COMMITTEE REPORTS

The following Reference Committee reports were acted upon by the House of Delegates.

ARTICLES OF INCORPORATION AND BY-LAWS AND LEGISLATION

The Reference Committee on Articles of Incorporation and By-Laws and Legislation met in open session at 2 p.m., Saturday, May 1, 1976. Comments were received on the various reports and resolutions during the nearly three-hour open hearing. It is gratifying to observe that more than 75 physicians attended the hearing and many provided constructive testimony.

The following report has been compiled in the belief and in the hope that the recommendations contained herein are in the best interests of the public and the profession. The Reference Committee submits the report for action by the House of Delegates.

RESOLUTION NO. 2—INTRODUCED BY CERRO GORDO COUNTY MEDICAL SOCIETY
EMERGENCY MEDICAL SERVICES
RESOLUTION NO. 6—INTRODUCED BY STORY COUNTY MEDICAL SOCIETY
EMERGENCY MEDICAL SERVICES
RESOLUTION NO. 9—INTRODUCED BY POLK COUNTY MEDICAL SOCIETY
EMERGENCY MEDICAL SERVICES

These nearly identical resolutions underscore the critical need for attention to the availability of emergency medical services in the State of Iowa, with leadership given to this important need by the medical profession.

RECOMMENDATION: The Reference Committee recommends adoption of the following substitute resolution in lieu of Resolutions No. 2, No. 6 and No. 9.

Resolved, That members of the Iowa Medical Society assume responsibility for active leadership in their local communities and surrounding areas for the development of effective care for patients who require emergency medical services, particularly in the pre-hospital and early hospital phases of care, and be it further

Resolved, That the Iowa Medical Society apprise the political leadership at all levels in our State of the need for financial and legislative support for the development of Emergency Medical Services programs.

Mr. Speaker, I move the adoption of this resolution.

SUPPLEMENTAL REPORT OF THE COMMITTEE ON EYE CARE

The Reference Committee was referred bracketed portion of the supplemental report of the Committee on Eye Care which appears on page 298 of this issue of the JOURNAL. Concern is raised in this material over possible legislation to authorize the use of diagnostic drugs by optometrists in the delivery of their services. Testimony at the hearing was in support of the supplemental report of the Committee on Eye Care.

RECOMMENDATION: The Reference Committee recommends adoption of the following resolutions.

Resolved, That the Iowa Medical Society oppose state legislation which permits the use of drugs by optometrists for diagnostic or therapeutic purposes, and be it further

Resolved, That the Iowa Medical Society affirm the basic belief that physicians in the practice of ophthalmology are the primary providers of eye care and that attempts to erode this concept be resisted actively.

Mr. Speaker, I move the adoption of these resolutions.

SUPPLEMENTAL REPORT OF THE SUBCOMMITTEE ON PUBLIC ASSISTANCE
RESOLUTION NO. 7—INTRODUCED BY BOONE COUNTY MEDICAL SOCIETY
TITLE XIX FUNDING

Summarized in the supplemental report of the Subcommittee on Public Assistance are the fiscal problems now being confronted by the Iowa Medicaid (Title XIX) Program. Reference is made to the recent and laudable action of the Iowa General Assembly in authorizing a supplemental appropriation of $13.8 million to allow the program to maintain at least its existing scope of benefits for the balance of the fiscal year.

Also noted is the financial uncertainty for the coming year. A $50 million appropriation approved this week by the Iowa Senate is predicted to be anywhere from $4 million to $7 million short of the anticipated need.

The potential of this underfunding is indeed serious. Already a number of physicians are reported to be declining to provide Medicaid services because of the existing restrictive reimbursement formula (estimated to pay approximately 60% of physician charges). A further curtailment of fees will impose an additional threat to the availability of care to those individuals eligible to receive services funded by Medicaid.

RECOMMENDATION: The following substitute resolutions are submitted in response to the Supplemental Report of the Subcommittee on Public Assistance and Resolution No. 7.

Resolved, That the Iowa Medical Society continue to urge the Iowa General Assembly to appropriate sufficient funds to allow all Medicaid (Title XIX) recipients to receive quality care commensurate with that care provided to all Iowans.

Mr. Speaker, I move the adoption of this resolution.

Resolved, That should state funding occur at a level which will not permit the program to be maintained at its existing level, the Iowa Medical Society urge that any program reduction be instituted in the area of scope of benefits and not in the area of provider reimbursement.

Mr. Speaker, I move the adoption of this resolution.

Resolved, That the Iowa Medical Society continue to be an active participant in the Medical Assistance Advisory Council and also engage independently in negotiations with the State Department of Social Services, assuring in doing so that the profession, through the Society and the Iowa Foundation for Medical Care, is willing to be responsible for the delivery of quality care in appropriate amounts and for fair reimbursement.

Mr. Speaker, I move the adoption of this resolution.

The balance of the Reference Committee report is concerned with matters relating to the complex problem of medical liability. As a preface to the recommendations which follow, it must be stated that the profession finds itself wrestling still with an unparalleled and almost insurmountable set of circumstances. The theory and practice of liability, as we have known it through the years, is impacting so volatilely on the professions, business and industry, municipal and state governments, etc., that some broad overhaul of the legal tort system seems inevitable.

RESOLUTION NO. 4—INTRODUCED BY DUBUQUE COUNTY MEDICAL SOCIETY
PUBLIC INFORMATION RE MEDICAL MALPRACTICE ISSUE

This resolution requests the Iowa Medical Society to conduct an advertising program in the state newspapers to provide physician views on medical malpractice. The Reference Committee is cognizant of the need in this area

as well as the financial burden such a program might impose. It is also aware of activities now being pursued by the Society in this area.

RECOMMENDATION: The Reference Committee recommends the adoption of the following substitute resolution.

Resolved, That the Iowa Medical Society give further attention to designing and implementing a public education program concerning professional liability, to include consideration of contacts with the press, and that this program be pursued under the direction of the Medico-Legal Committee and the Board of Trustees.

Mr. Speaker, I move the adoption of this resolution.

RESOLUTION NO 8—INTRODUCED BY DUBUQUE COUNTY MEDICAL SOCIETY MALPRACTICE
RESOLUTION NO. 19—INTRODUCED BY SCOTT COUNTY MEDICAL SOCIETY MALPRACTICE

These two resolutions are similar in intent and request the Society to study and undertake a litigatory program in an effort to focus appropriate and significant attention on the non-meritorious nature of some malpractice suits.

RECOMMENDATION: The Reference Committee recommends adoption of the following substitute resolution in lieu of Resolutions No. 8 and No. 19.

Resolved, That the Iowa Medical Society undertake a study and evaluation of those programs in other states, including the plan recently adopted by the Illinois State Medical Society, which involve legal counteraction to non-meritorious litigation, and be it further

Resolved, That the Iowa Medical Society aggressively pursue and identify a case or cases appropriate for countersuit and report the findings of this search and the potential in this area to the Executive Council within six months, with the Executive Council given authority to determine the course of action to be taken.

Mr. Speaker, I move the adoption of these resolutions.

RESOLUTION NO. 12—INTRODUCED BY THE DUBUQUE COUNTY MEDICAL SOCIETY MALPRACTICE

This resolution calls for public disclosure by the insurance industry of all malpractice liability claims made and paid for. No representative of the sponsoring society was present to elaborate on the intent of the resolution. Testimony presented to the Reference Committee indicates that efforts are now in process to gather salient information on all closed claims. Such a study is now in process through the National Association of Insurance Commissioners, which holds the prospect of being useful in the future development of remedial measures.

RECOMMENDATION: The Reference Committee recommends adoption of the following resolution.

Resolved, That Resolution No. 12 be referred to the Medico-Legal Committee for its consideration in light of existing activities in this area.

Mr. Speaker, I move the adoption of this resolution.

RESOLUTION NO. 18—INTRODUCED BY IDA COUNTY MEDICAL SOCIETY PROFESSIONAL LIABILITY

This resolution seeks the adoption of a mechanism to require patients to sign a form in advance of treatment which indicates ideal results may not be attainable and that such an outcome must be accepted in the absence of gross negligence. The Reference Committee is advised that such a document would bear little legal weight.

The Reference Committee acknowledges that the resolution may have merit in that it underscores the need for assuring patients that an optimal treatment result is not always possible.

RECOMMENDATION: The Reference Committee recommends adoption of the following resolution.

Resolved, That Resolution No. 18 be not adopted.

Mr. Speaker, I move the adoption of this resolution.

SUPPLEMENTAL REPORT OF THE MEDICO-LEGAL COMMITTEE RESOLUTION NO. 15—INTRODUCED BY THE BLACK HAWK COUNTY MEDICAL SOCIETY MALPRACTICE LEGISLATION

The comprehensive supplemental report of the Medico-Legal Committee (plus the oral remarks of Drs. Young and Denser before the opening session of the House) and Resolution No. 15 speak to the status of legislation currently before the Iowa General Assembly.

In addition, the supplemental report provides a good status report on the availability of liability coverage in Iowa. The liaison which has been carried on by Society representatives with the insurance industry, the Iowa Insurance Department, the Iowa General Assembly, and the most seriously affected specialty groups is worthy of commendation.

RECOMMENDATION: The following resolutions are offered in response to the supplemental report of the Medico-Legal Committee and in lieu of Resolution No. 15.

Resolved, That the Society continue to seek effective state legislation to build on House File 803, with the goal of bringing equity and stability into the professional liability picture.

Mr. Speaker, I move the adoption of this resolution.

Resolved, That in view of legislative developments in recent days, namely passage by the Iowa Senate of a meaningless bill, that every member of this 1976 House of Delegates, plus all legislative contact men and other physicians, contact their Representatives (members of the Iowa House of Representatives) this weekend (or prior to Tuesday, May 4) to urge adoption of those Society-sponsored amendments intended to restore the Senate bill to a meaningful condition, or short of that, to oppose passage of any legislation in this session of the Assembly.

Mr. Speaker, I move the adoption of this resolution.

Resolved, That through the Medico-Legal Committee and other resources available, the Society give further attention to the establishment of an excess fund to resolve this most acute area of the liability problem, and in doing so, give as much creative thought as possible to the structure of such a plan outside of governmental control.

Mr. Speaker, I move the adoption of this resolution.

Resolved, That the Society provide support to those specialty groups hardest hit by the liability problem, including most especially the anesthesiologists, and assist each of them to the fullest extent possible and prudent in demonstrating their plight to the legislators and to the public.

Mr. Speaker, I move the adoption of this resolution.

Resolved, That the Society maintain its active liaison with the insurance industry and pursue with any reputable company the possibility of a Society-sponsored, group type coverage, with any such program to be presented for approval either to the Executive Council or the House of Delegates.

Mr. Speaker, I move the adoption of this resolution.

Resolved, That the Society assign a top priority to the gathering of statistical data on professional liability experience in Iowa and elsewhere upon which logical and defensible remedial measures can be based, knowing that in doing so, we confront a societal problem which in time must be resolved by a total revamping of the legal tort system.

Mr. Speaker, I move the adoption of this resolution.

This concludes the Report of the Reference Committee on Articles of Incorporation and By-Laws and Legislation.

E. B. GROSSMAN, M.D., *Chairman*
J. C. BARKER, M.D.
J. L. GARRED, M.D.
S. W. GREENWALD, M.D.
D. J. WALTER, M.D.

COMMITTEE ON INSURANCE AND MEDICAL SERVICE

The Reference Committee on Insurance and Medical Service met at 2:05 p.m. on Saturday, May 1, 1976 to receive testimony on the resolutions and reports referred to it. Approximately 35 physicians attended the meeting, which adjourned at 4:00 p.m.

SUPPLEMENTAL REPORT OF THE COMMITTEE ON EYE CARE

A Supplemental Report from the IMS Committee on Eye Care outlined a vision care indemnity program suggested by the committee and officials of Blue Cross/Blue Shield. The House of Delegates two years ago reviewed the program and the Committee on Eye Care has researched the subject since that time. The program is designed to offer indemnity vision care coverage administered by Blue Cross/Blue Shield. Eligible providers would include licensed physicians and optometrists. Payment would be made directly to participating physicians or to the subscriber for services of non-participating physicians or optometrists. Detailed data on the program is contained in the Supplemental Report.

RECOMMENDATION: *Resolved,* That the IMS House of Delegates approve the Vision Care Program as proposed by the Committee on Eye Care.

Mr. Speaker, I move the adoption of this resolution.

REPORT OF THE IOWA FOUNDATION FOR MEDICAL CARE

The Iowa Foundation for Medical Care presented a comprehensive status report regarding PSRO and Peer Review. It reported that the Articles of Incorporation and By-Laws will need to be revised to meet specific provisions of the PSRO law and these changes were outlined in the report.

Mr. Speaker, I move the acceptance of the foregoing portion of this report as information for the House.

The Iowa Foundation for Medical Care has become aware of the lack of clear policy regarding the Foundation's authority to recommend to health insurance companies policy and claim payment guidelines which differ or modify guidelines previously adopted by the Iowa Medical Society House of Delegates and recommends the following:

RECOMMENDATION: *Resolved,* That the Iowa Medical Society Board of Trustees be empowered to meet with the Iowa Foundation for Medical Care Board of Directors to formulate a memorandum of understanding to grant such authority to the Foundation to establish claim payment guidelines for third parties based on the authority of this House of Delegates; and be it further

Resolved, That such a memorandum of understanding provide mechanisms for informing physicians of such policy and claim payment guidelines.

Mr. Speaker, I move the adoption of this resolution.

RESOLUTION NO. 11—INTRODUCED BY POLK COUNTY MEDICAL SOCIETY CUSTOMARY FEE UPDATE

Presently, Blue Shield updates usual fee profiles twice a year and customary charge profiles once each year. This policy has been approved by the Iowa Medical Society House of Delegates and the State Insurance Department. The committee feels the Insurance Department would look upon a twice-yearly customary fee update as excessively inflationary and could cause the department to withdraw approval for Blue Shield to market the UCR contract. The Committee believes that a yearly update of customary is adequate, especially in view of the present policy of updating usual fees twice each year.

RECOMMENDATION: The Reference Committee recommends that Resolution No. 11 not be adopted.

Mr. Speaker, I move adoption of this recommendation.

RESOLUTION NO. 14—INTRODUCED BY CHEROKEE COUNTY MEDICAL SOCIETY MULTIPHASIC HEALTH TESTING PROGRAMS IN IOWA

Several multiphasic health programs are operating in Iowa and it is reported that some of these programs do not appear to comply with AMA guidelines. Program planning and development are not always supervised by local physicians and quality control is unknown. Members of the Reference Committee recognize that many physicians in Iowa generally are skeptical of the worth of these programs. The Iowa Medical Society, in consultation with legal counsel, the AMA, State Board of Medical Examiners and others, has attempted to closely monitor the multiphasic testing programs, but has been unable to document a legal challenge to the provision of these services. The Reference Committee agrees in substance with the concept of Resolution No. 14, but recommends the following substitute resolution:

RECOMMENDATION: *Resolved,* That the Iowa Medical Society cooperate with multiphasic health testing programs in Iowa only after such programs have demonstrated (1) reliability of services and quality control; (2) medical direction by an Iowa-licensed physician; and (3) willingness to seek approval by the local county medical society *before* operation in the area; and be it further

Resolved, That a committee of the Iowa Medical Society designated by the Board of Trustees be, and it hereby is, directed to establish an educational program which will inform the general public of the value of appropriate multiphasic screening.

Mr. Speaker, I move the adoption of this resolution.

RESOLUTION NO. 17—INTRODUCED BY WRIGHT COUNTY MEDICAL SOCIETY BLUE SHIELD UCR FEE PROFILES

No one from Wright County was present to discuss the resolution so the Reference Committee is unable to fully evaluate the intent of the resolution. Blue Shield presently follows fee profile determination on a statewide basis by specialty as recommended by the House of Delegates. In view of these factors, the Reference Committee submits the following:

RECOMMENDATION: That Resolution No. 17 not be approved.

Mr. Speaker, I move the adoption of this recommendation.

RESOLUTION NO. 20—INTRODUCED BY POLK COUNTY MEDICAL SOCIETY
OFFICE OVERHEAD REIMBURSEMENT

The Resolution states that the public is sometimes confused regarding the benefits contained under Blue Cross coverage as contrasted to Blue Shield. The Reference Committee feels that Resolution No. 20 requires detailed study to measure and evaluate its impact, and suggests that it be referred to an appropriate IMS committee.

RECOMMENDATION: *Resolved,* That Resolution No. 20 be referred to the IMS Committee on Medical Service for further study in order to properly inform both physicians and the public of the benefits available for office overhead costs.

Mr. Speaker, I move the adoption of this resolution.

This concludes the report of the Reference Committee on Insurance and Medical Service.

G. E. MICHEL, M.D., *Chairman*
W. G. GARRETT, M.D.
T. C. GRAHAM, M.D.
J. E. MCGEE, M.D.
D. C. TROST, Student

REPORTS OF OFFICERS AND MISCELLANEOUS BUSINESS

Many physicians and members of the House of Delegates offered comments and suggestions on the various items referred to the Reference Committee on Reports of Officers and Miscellaneous Business. The following recommendations are presented for action by the House of Delegates:

SUPPLEMENTAL REPORT OF BOARD OF TRUSTEES—
SECTION I/GENERAL ACTIVITIES

Although no action is required with respect to the summary of general activities outlined in Section I of the Board of Trustees report, the Reference Committee wishes to commend the officers for their efforts on behalf of the membership in overseeing the general business affairs and overall activities of the Society.

The Reference Committee also wishes to underscore the Board's comments regarding the excellent relationship and spirit of cooperation that exists between the IMS and the University of Iowa College of Medicine. In this regard, Doctor John Eckstein, Dean of the College of Medicine, and other officials and faculty at the medical school, are to be commended for taking positive steps to enhance intraprofessional communications in response to concerns expressed by the House of Delegates last year.

Mr. Speaker, I move the adoption of this portion of the report.

SUPPLEMENTAL REPORT OF BOARD OF TRUSTEES—
SECTION II/COMMUNICATIONS

The review of the Society's overall communications program demonstrates the great amount of effort to keep the membership informed on the myriad of projects implemented by the Society and the critical issues confronting medicine. In response to proposals from the Board of Trustees re the communications program of the Society, the Reference Committee offers the following resolutions:

RECOMMENDATION: *Resolved,* That the name of the JOURNAL OF THE IOWA MEDICAL SOCIETY be retained, and be it further

Resolved, That the members of the Iowa Medical Society be surveyed regarding the desirability and need for an additional publication or supplement to the JOURNAL OF THE IOWA MEDICAL SOCIETY geared to the interest of the lay public, and be it further

Resolved, That the Board of Trustees be encouraged to continue to explore and implement effective written communications with the members, including the new monthly publication IMS UPDATE, and be it finally

Resolved, that the Board of Trustees be supported in a continuation of 1975-76 efforts to (a) present information at sites around the state, and (b) conduct conferences and seminars for physician groups at IMS headquarters.

Mr. Speaker, I move adoption of the foregoing resolutions.

SUPPLEMENTAL REPORT OF BOARD OF TRUSTEES—
SECTION III/FINANCES

It is noteworthy that the following financial objectives have been achieved: (a) a reversal of the deficit financing patterns which developed as a consequence of an accelerated mortgage payment program, and (b) the establishment of a reserve fund.

RECOMMENDATION: *Resolved,* That membership dues in the Iowa Medical Society for 1977 be maintained at the present level of $200 per member, recognizing that with such action a restriction will need to be placed on additional services, programs, and staff; further, based on present circumstances, a dues increase in 1978 seems likely, the exact amount to be determined by the 1977 House of Delegates, and be it further

Resolved, That members of the House of Delegates report to their component societies on the improved financial situation of the IMS, and explain that, in light of inflation and in order to maintain the present level of activity and achievements, a dues increase may be necessary in 1978.

Mr. Speaker, I move adoption of the foregoing resolutions.

REPORT OF THE COMMITTEE ON
DELIVERY OF HEALTH SERVICES
RESOLUTION NO. 5—INTRODUCED BY DUBUQUE COUNTY MEDICAL SOCIETY
SUPERVISION OF PHYSICIAN ASSISTANT

Considerable testimony was presented regarding the utilization of the physician's assistant, and concern was expressed regarding the future role of this new member of the health care team. The Reference Committee wishes to remind the House of Delegates that in 1971 the IMS Executive Council approved a recommendation that the IMS endorse the development of a physician's assistant program, and supported appropriate enabling legislation for PA's calling for the administration of a PA program by the Board of Medical Examiners.

RECOMMENDATION: *Resolved,* That in light of the need for pertinent and accurate information regarding the effectiveness and efficiency of the physician extender (i.e., physician's assistant and family nurse practitioner), the IMS, through its Committee on Delivery of Health Services, (a) collect and review information on this subject available from various sources in the state; (b) arrange a conference involving physician extenders, their supervising physicians, and other interested parties, to discuss the "pros and cons" of the use and value of physician extenders; and (c) based on the results of the information obtained from these sources, develop a formal position

statement relating to the role and utilization of the physician extender in Iowa for consideration by the IMS Executive Council and/or House of Delegates.

Mr. Speaker, I move the adoption of the foregoing resolution.

RECOMMENDATION: Be it further resolved, that Resolution No. 5 be referred to the Committee on Delivery of Health Services for further study and report back to the Executive Council and/or House.

AD HOC COMMITTEE ON 1976 NATIONAL SWINE VIRUS VACCINE PROGRAM

The Reference Committee believes it is impossible to adequately assess the medical need for a mass swine virus vaccination program; however, in light of governmental actions, taken at the national and state levels, as well as support expressed by the American Medical Association for a mass vaccination program, the following Resolution is offered:

RECOMMENDATION: *Resolved,* That the Iowa Swine Influenza Immunization Plan be approved by the Iowa Medical Society, subject to local modification and adaptation to more effectively serve the county or community involved.

Mr. Speaker, I move the adoption of the foregoing resolution.

RESOLUTION NO. 1—INTRODUCED BY SCOTT COUNTY MEDICAL SOCIETY SCHOOL PHYSICAL EXAMINATIONS

The Reference Committee notes that although there is a state statute requiring physical examinations for students involved in high school athletic programs, it is left to local school boards to determine whether or not a general physical examination is required for all school children. In light of this information, the Reference Committee recommends the adoption of Resolution No. 1, with two additional resolves:

RECOMMENDATION: *Resolved,* That the Iowa Medical Society exert all its influence to encourage or require that physical examinations of children for school purposes be performed only by licensed medical doctors or osteopathic physicians and surgeons or under their appropriate medical supervision; and be it further

Resolved, That this recommendation be called to the attention of the State Department of Health and State Department of Public Instruction, and be it further

Resolved, That the Maternal and Child Health Committee of the IMS investigate and formulate recommendations with respect to the feasibility of supporting legislation to require all children to receive a physical examination for entry into school.

Mr. Speaker, I move adoption of these resolutions.

RESOLUTION NO. 3—INTRODUCED BY DUBUQUE COUNTY MEDICAL SOCIETY PHYSICAN REPRESENTATION IN HSA

Resolution No. 3 refers to the composition of the Board of Directors of Iowa's Health Systems Agency. The Reference Committee wishes to note that of 13 provider representatives elected to the Board, 4 are M.D.'s and 1 is a D.O. In addition, physician representatives have been elected to each of the five subarea advisory councils.

In light of this information, the Reference Committee wishes to recommend that the following substitute resolution be adopted in lieu of Resolution No. 3:

RECOMMENDATION: *Resolved,* That the Iowa Medical Society continue to work vigorously to assure participation and involvement of physicians as provider representatives on sub-area advisory councils and as members of Board of Directors of Iowa's Health Systems Agency.

Mr. Speaker, I move adoption of the foregoing resolution.

RESOLUTION NO. 10—INTRODUCED BY POLK COUNTY MEDICAL SOCIETY UNIFIED MEMBERSHIP

The committee submits the following amended resolution:

RECOMMENDATION: *Resolved,* That the concept of unified membership in all components of organized membership (county, state, national) be considered for establishment in the State of Iowa; that the IMS Committee on Articles of Incorporation and Bylaws draft appropriate language to implement the unified membership requirement, and that such language be submitted to the House of Delegates for consideration and action in 1977.

Mr. Speaker, I move adoption of the foregoing resolution.

RESOLUTION NO. 13—INTRODUCED BY DUBUQUE COUNTY MEDICAL SOCIETY DISASTER SUPPORT SYSTEM

Resolution No. 13 proposes the development of a disaster support system of physicians on a volunteer basis to include transportation of the team by the U. S. Air Force on a 24-hour notice to any place in North and South America.

The committee recommends that the following substitute resolution be adopted in lieu of Resolution No. 13:

RECOMMENDATION: *Resolved,* That the concept of a disaster support system of physicians on a volunteer basis be endorsed, and be it further

Resolved, That a copy of Resolution No. 13 be provided to the IMS Committee on Emergency Medical Services and to the Governor's Emergency Medical Service Advisory Council for their information and consideration in developing a possible plan for a disaster support system of physicians.

Mr. Speaker, I move adoption of these resolutions.

RESOLUTION NO. 16—INTRODUCED BY POLK COUNTY MEDICAL SOCIETY TRIBUTE TO HERMAN J. SMITH, M.D.

Resolution No. 16 proposes special recognition for Herman J. Smith, M.D., via the designation of a special presentation at annual IMS scientific sessions. The committee recommends that the following substitute resolution be adopted in lieu of Resolution No. 16:

RECOMMENDATION: *Resolved,* That the Board of Trustees of the Iowa Medical Society, in consultation with officials of the Polk County Medical Society, establish an appropriate memorial to honor Herman J. Smith, M.D.

Mr. Speaker, I move adoption of this resolution.

This concludes the report of the Reference Committee on Reports of Officers and Miscellaneous Business. I wish to express appreciation to the members of this committee and also to all of the physicians who participated in the discussion at the open hearing.

J. H. CODDINGTON, M.D., *Chairman*
C. E. HARTFORD, M.D.
A. C. HASS, M.D.
E. B. MATHIASEN, M.D.
A. S. OWCA, M.D.

Dr. Caraway expressed appreciation to the delegates for their cooperation during the sessions of the House. The Speaker then asked for new business. Dr. Bliss moved the House of Delegates approve the action of the IMS Board of Trustees from the date of the last previous annual meeting. The motion, as follows, was seconded and adopted:

Resolved, That the actions of the Board of Trustees of the Iowa Medical Society from the date of the last annual meeting be and hereby are ratified and confirmed.

Dr. Bliss acknowledged the long and dedicated service to the medical profession of Dr. Verne L. Schlaser, and recognized Dr. Schlaser, in particular, on behalf of the Society's officers, for a job well done. The House responded unanimously.

Dr. Caraway announced organizational meetings of the Board of Trustees and Judicial Council would occur immediately following adjournment of the House of Delegates and the installation of Dr. Bishop as new IMS president. Dr. Bishop addressed the House briefly. The House of Delegates was adjourned at 10:10 a.m.

IOWA MEDICAL SOCIETY
Officers and Committees, 1976-1977

President ..... J. F. Bishop, Davenport
President-Elect ..... L. W. Swanson, Mason City
Vice President ..... A. W. Boone, Davenport
Secretary ..... W. R. Bliss, Ames
Treasurer ..... T. A. Burcham, Des Moines
Speaker of the House of Delegates ..... L. D. Caraway, Amana
Vice Speaker of the House of Delegates
..... J. H. Lohnes, Cedar Rapids

COUNCILORS

	Term Expires
First District, C. L. Kelly, Jr., Charles City	1979
Second District, W. V. Wulfekuhler, Mason City	1977
Third District, D. F. Rodawig, Jr., Spirit Lake	1978
Fourth District, D. M. Youngblade, Sioux City	1979
Fifth District, D. J. Walter, Des Moines	1977
Sixth District, A. M. Dolan, Waterloo	1979
Seventh District, J. E. Tyrrell, Manchester, Chairman	1977
Eighth District, R. L. Kent, Fort Madison	1977
Ninth District, S. A. Smith, Oskaloosa	1977
Tenth District, J. D. Kimball, Osceola	1978
Eleventh District, A. L. Sciortino, Council Bluffs	1979
Twelfth District, E. E. Linder, Ogden	1977

TRUSTEES

A. J. Havlik, Tama, Chairman	1979
J. H. Kelley, Des Moines	1977
Hormoz Rassekh, Council Bluffs	1978

DELEGATES TO AMA

Erling Larson, Jr., Davenport	December 31, 1978
J. R. Anderson, Boone	December 31, 1977
J. M. Rhodes, Sr., Pocahontas	December 31, 1978
C. H. Denser, Jr., Des Moines	December 31, 1978
R. D. Whinery, Iowa City	December 31, 1978

ALTERNATE DELEGATES TO AMA

J. R. Scheibe, Bloomfield	December 31, 1976

EXECUTIVE COUNCIL

J. F. Bishop	Davenport
L. W. Swanson	Mason City
A. W. Boone	Davenport
W. R. Bliss	Ames
T. A. Burcham	Des Moines
A. J. Havlik	Tama
J. H. Kelley	Des Moines
H. Rassekh	Council Bluffs
C. L. Kelly, Jr.	Charles City
W. V. Wulfekuhler	Mason City
D. F. Rodawig, Jr.	Spirit Lake
D. M. Youngblade	Sioux City
D. J. Walter	Des Moines
A. M. Dolan	Waterloo
J. E. Tyrrell	Manchester
R. L. Kent	Fort Madison
S. A. Smith	Oskaloosa
J. D. Kimball	Osceola
A. L. Sciortino	Council Bluffs
E. E. Linder	Ogden
Erling Larson, Jr.	Davenport
J. R. Anderson	Boone
J. M. Rhodes, Sr.	Pocahontas
J. R. Scheibe (non-voting)	Bloomfield
C. H. Denser, Jr. (non-voting)	Des Moines
R. D. Whinery (non-voting)	Iowa City
L. D. Caraway	Amana
C. W. Seibert	Waterloo
J. D. Ver Steeg	Des Moines
V. L. Schlaser	Des Moines

THE JOURNAL

M. E. Alberts	Des Moines

Standing Committees of the Iowa Medical Society

COMMITTEE ON ARTICLES OF INCORPORATION AND BY-LAWS

K. J. Judiesch, Chairman	Iowa City
T. M. Gary	Cherokee
P. J. Leehey	Independence
H. L. Skinner	Carroll
L. W. Swanson	Mason City

BLUE SHIELD LIAISON COMMITTEE (TERMS EXPIRE JULY 1976)

E. E. Linder	Ogden
C. E. Radcliffe	Iowa City
J. F. Bishop	Davenport
A. J. Havlik	Tama
W. R. Bliss	Ames
L. W. Swanson	Mason City

GRIEVANCE COMMITTEE

District 1—D. O. Maland ..... Cresco
District 2—G. H. West ..... Mason City
District 3—E. B. Grossmann, Jr. (Secretary) ..... Orange City
District 4—D. E. Boyle ..... Sioux City
District 5—John Hess, Jr. ..... Des Moines
District 6—L. L. Zager ..... Waterloo
District 7—S. E. Ziffren, Chairman ..... Iowa City
District 8—R. J. Rettenmaier ..... Burlington
District 9—B. W. Frommack ..... Pella
District 10—D. D. Wilken ..... Osceola
District 11—J. L. Knott ..... Council Bluffs
District 12—W. A. Johnson ..... Ames

COMMITTEE ON HEALTH EDUCATION

C. D. Ellyson, Chairman ..... Waterloo
C. H. Gutenkauf ..... Des Moines
Eugene Johnson ..... LeClaire
G. M. Kuehn ..... Mason City

COMMITTEE ON LEGISLATION

D. C. Young, Chairman ..... Des Moines
J. C. Barker ..... Davenport
C. L. Beye ..... Sioux City
J. F. Bishop ..... Davenport
W. R. Bliss ..... Ames
G. R. Clark ..... Waterloo
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About IOWA Physicians

Dr. K. D. Rodabaugh, Tabor, was recently named to advisory board of Planned Parenthood Center of Red Oak. . . . Recent initiates of The Alpha of Iowa Chapter of Alpha Omega Alpha, national honorary medical society, are **Dr. Kenneth Lister,** Ottumwa, **Dr. Robert B. Stickler,** Des Moines, and four U. of I. College of Medicine faculty members **—Drs. Ronald M. Lauer, Francis Abboud, Reginald R. Cooper** and **David A. Culp . . . Dr. Einer Juel, Atlantic,** was recently cited by Southwest Iowa Mental Health Center for his distinguished service in mental health field. Award was presented at third annual board workshop of the Iowa Mental Health Authority and the Community Mental Health Centers Association of Iowa, Inc.

Drs. Janusz Bardach, Charles J. Krause, and **David E. Schuller,** faculty members in the U. of I. department of otolaryngology and maxillofacial surgery, presented a paper on "Irradiated Homograft Costal Cartilage for Facial Contour Restoration," at twelfth annual scientific meeting of the American Academy of Facial Plastic and Reconstructive Surgery, Inc. . . . **Dr. James J. Puhl** and **Dr. James P. O'Hara** have joined the Steindler Orthopedic Clinic in Iowa City. . . . **Dr. S. Donald Zaentz,** Ames, **Dr. Thomas J. McIntosh,** Cedar Rapids, **Dr. Liberato A. Iannone,** Des Moines, and **Dr. Mitchell L. Rhodes,** Iowa City, were elected Fellows of American College of Physicians at recent meeting of the College's Board of Regents in Philadelphia. . . . **Dr. Robert Boldus,** Sioux City, and **Dr. Curtis Clark,** Ames, were program participants at spring meeting of Iowa Urological Society. . . . **Dr. Paul Kersten,** Fort Dodge, was named "Boss of the Year" at recent Fort Dodge meeting of American Business Women's Association. A similar award was accorded recently to **Dr. Dennis Walter,** Des Moines.

Dr. Emmett Mathiasen, Council Bluffs, was recently elected president of the Iowa Clinical Surgical Society. **Dr. Edward Mason,** professor in department of surgery at U. of I. College of Medicine, was named president-elect. . . . **Dr. Thomas Altemeier** began family practice in Iowa Falls in May. A native of Newton, Dr. Altemeier received the M.D. degree at U. of I. College of Medicine and completed his family practice residency at Broadlawns Hospital in Des Moines. . . . **Dr. Joseph B. Peraud** and **Dr. Mary Sharon Peraud,** husband and wife, will begin family practice in Fredericksburg this summer. They are presently completing family practice residencies at Broadlawns Hospital in Des Moines. Both received their M.D. degrees at U. of I. College of Medicine. Dr. Mary Sharon Peraud is a sister of **Dr. James Carr,** New Hampton physician.

Dr. and Mrs. Dale Wassmuth, Sioux City, are 1976 co-winners of the Key Award presented by the Siouxland Chapter of Iowa State University Alumni Association. . . . **Dr. E. J. Gottsch,** Shenandoah physician for 57 years, retired May 29. Dr. Gottsch began his practice in Shenandoah in 1919. He received the M.D. degree at U. of I. College of Medicine; interned at Montreal General Hospital in Canada and completed surgery residency at Winnipeg General Hospital. Dr. Gottsch is an IMS life member. . . . **Dr. R. A. Jongewaard,** an Orange City native, joined **Dr. L. J. Willekes** in Sioux Center July 1. Dr. Jongewaard received the M.D. degree at U. of I. College of Medicine and completed a family practice residency at Sioux Valley Hospital in Sioux Falls, South Dakota. . . . **Dr. W. H. Verduyn,** Reinbeck, was recently recognized by Mayo Medical School for his service to students in the Department of Family Medicine. . . . **Dr. Ivan E. Brown,** Hartley, was recently cited in Hartley SENTINEL for his 25 years

of medical service to the community. . . . **Dr. Walter M. Block,** Cedar Rapids, participated in a recent Family Practice Residency Program at University of Wisconsin in Madison. Dr. Block discussed the Cedar Rapids Evaluation Clinic and spoke on "Diagnosis and Management of Children with Cerebral Dysfunctions." . . . At annual meeting of American College of Obstetricians and Gynecologists, **Dr. Melvin R. Kelberg,** Sioux City, was recognized for his 25 years of service as Founding Fellow of the College.

Dr. Terry F. Dynes, Decorah, recently attended a training session in Advanced Cardiac Life Support at American Heart Association's National Center in Dallas, Texas. . . . **Dr. and Mrs. Herbert W. Rathe,** Waverly, celebrated their 50th wedding anniversary June 6. The event also marked Dr. Rathe's 50 years in medicine in Waverly. . . .

Dr. K. T. Song, Mason City, was guest speaker at the May meeting of the Wright County Medical Society. Dr. Song summarized the hemodynamics and treatment of patients with vascular surgery problems.

DEATHS

Dr. Edgar B. Wilcox, 98, Oskaloosa, died at Mahaska Hospital on April 1. Dr. Wilcox received the M.D. degree at University of Kentucky Medical School, and interned at Louisville Community Hospital. He began his practice of medicine in Oskaloosa in 1908, retiring in 1962. Dr. Wilcox was a past president and charter member of the Oskaloosa Kiwanis Club; past president of Mahaska County Medical Society; member of American College of Surgeons and life member of Iowa Medical Society.

Morbidity Report for May, 1976

Disease	May 1976	1976 to Date	1975 to Date	Most May Cases Reported From These Counties
Amebiasis	9	26	10	Boone
Brucellosis	1	10	11	Dubuque
Chickenpox	1764	9320	6420	Dubuque, Johnson, Linn Polk
Conjunctivitis	378	1387	798	Black Hawk, Linn, Van Buren
Coxsackie infection	1	1	—	Johnson
Erythema infectiosum	57	138	132	Chickasaw
Gastrointestional viral infect.	1407	16079	14563	Chickasaw, Davis, Floyd
Giardiasis	2	15	7	Floyd, Wapello
Hepatitis				
A (infectious)	12	57	83	Johnson, Scott
B (serum)	14	39	44	Polk, Pottawattamie, Scott
Unspecified	1	9	18	Mills
Impetigo	93	468	320	Black Hawk, Lee, Linn, Scott
Infectious mononucleosis	142	628	751	Adair, Linn, Polk, Scott
Influenza-like illness	1893	39102	35974	Davis, Linn, Polk
Influenza, lab confirmed	11	154	159	Johnson, Polk
Mumps	244	1135	912	Jasper, Keokuk, Polk
Pediculosis	33	249	190	Cerro Gordo, Scott
Pinworms	1	10	23	Linn
Pneumonia	41	650	621	Scott, Johnson
Rabies in animals	15	50	41	O'Brien, Winneshiek
Rheumatic fever	2	16	9	Hancock, Scott
Ringworm, body	21	161	169	Black Hawk, Clark, Delaware
Ringworm, scalp	7	18	7	Hancock
Rubella	27	39	18	Polk
Rubeola	2	29	404	Crawford, Montgomery
Salmonella	9	48	71	Buena Vista, Scott
Scabies	99	400	225	Kossuth, Polk, Clinton
Shigellosis	17	29	31	Scott, Pottawattamie
Streptococcal infection	1164	9868	6074	Black Hawk, Jackson, Johnson
Trichuriasis	3	8	—	Floyd, Wapello
Tuberculosis				
(total ill)	8	47	58	Polk
(bact. positive)	7	42	26	Polk
Tularemia	1	1	—	Polk
Venereal Diseases				
Gonorrhea	535	2670	2574	Black Hawk, Polk, Linn, Scott
Syphilis	19	142	130	Black Hawk, Polk

Laboratory Virus Diagnosis Without Specified Clinical Syndrome
Adenovirus 1, Cytomegalovirus infection 3, Herpes simplex 15, Parainfluenza type 1-2

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(Continued from page 319)

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respond to one

According to her major
ıptoms, she is a psychoneu-
c patient with severe
iety. But according to the
cription she gives of her
ings, part of the problem
sound like depression.
s is because her problem,
ough primarily one of ex-
ive anxiety, is often accom-
ied by depressive symptom-
ogy. Valium (diazepam)
provide relief for both—as
excessive anxiety is re-
ed, the depressive symp-
s associated with it are also
n relieved.

There are other advan-
s in using Valium for the
nagement of psychoneu-
c anxiety with secondary
ressive symptoms: the
chotherapeutic effect of
ium is pronounced and
d. This means that im-
vement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

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in psychoneurotic
anxiety states
with associated
depressive symptoms

eillance because of their predisposi-
to habituation and dependence. In
nancy, lactation or women of child-
ing age, weigh potential benefit
nst possible hazard.

autions: If combined with other psy-
ropics or anticonvulsants, consider
fully pharmacology of agents em-
ed; drugs such as phenothiazines,
otics, barbiturates, MAO inhibitors
other antidepressants may potentiate
tion. Usual precautions indicated in
nts severely depressed, or with latent
ession, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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President's Page

This is a commercial. The 1977 IMS Scientific Session, slated to be out of the state, will be held at Telemark Lodge, just outside Cable in northwestern Wisconsin in mid-July. It will involve three days in mid-week at bargain prices. The management has agreed to accept the same room charges for the days before and after the meeting to make it easy to stay all week. There will be golf, tennis, swimming pools, horseback riding, fishing, and, if desired, shopping tours to Duluth, and Hayward, Wisconsin. The meeting should lend itself to a family vacation.

The Committee is busy on the program and there will be more information later. Just tuck the time away in the back of your mind, mid-July, 1977.

James F. Bishop, M.D.

James F. Bishop, M.D., President

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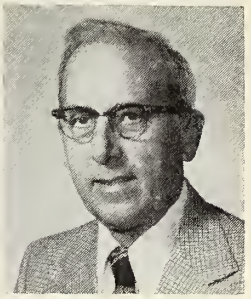
The Question Box



by JOHN ROSS

NEW HSA EXEC COMMENTS

John Ross became executive director of the Iowa Health Systems Agency (HSA) April 1. He comes to Iowa from a health planning position in St. Joseph, Michigan. He comments here on the status of Iowa's HSA as of July.

The Iowa Health Systems Agency (HSA) is at what point in its organizational process?

The Iowa Health Systems Agency is nearing completion of the organizational process. Articles of Incorporation, Bylaws and Board membership selection were completed May 10. Standing committees of the Board, including individuals from both the Board and the 5 Subarea Advisory Councils, were appointed on July 12. Each of the 5 Advisory Councils is in the process of appointing its standing committees. To date, over 400 community-minded health professionals and other citizens are involved with the agency. Still to be formed are ad-hoc technical committees which will involve several hundred additional volunteers. Many of these positions will be open to members of the Iowa Medical Society even though the IMS member is not already involved with an Advisory Council or a standing committee of the Health Systems Agency.

Staff acquisition is also proceeding at a satisfactory pace. Of the budgeted 22 professionals, 9 were employed by June 1 and 15 by July 1. Staff is organized into 4 functional sections and an administrative section. These sections are: Research and Data Management, Plan Development, Plan Implementation, and Field Services. A director for each section has been employed and each section is operational from the agency's newly remodeled and redecorated headquarters in the Fleming Building in Des Moines. Additional staff is being employed to deliver the Agency's services from 5 field offices around the state.

What objectives do you hope to see achieved in the next 6 to 12 months?

Our objective for this first year is to complete the writing of a Health Systems Plan and an Annual Implementation Plan as required under the law creating Health Systems Agencies. The Health Systems Plan will be a statement of goals to be reached by 1982. The Annual Implementation Plan will detail specific activities to be undertaken in 1977 in support of the longer range goals. There are problems with our achieving that objective within the referenced time frame, but it is my hope these obstacles are being overcome. The problems are a meager level of funding, a fragmented data base, a federal bureaucracy that to date has been unable to keep pace with the timelines it established for itself and a need to gain acceptance of plans from a community that is unsure of where such plans lead. Hope for overcoming the funding obstacle rests with soliciting strong local support and a strong possibility of Congress appropriating additional monies. To pull together the data base needed, approximately 50 percent of the staff effort has been allocated to that function and this concentration of effort is producing the hoped for results. Assisting the federal bureaucracy in getting back into step with our local agency, we initiated a two-day conference of directors from the midwest. The conference produced agreement on formats for the plans to be written and a strong indication that the format would be acceptable to the bureaucracy when its format is finalized. Finally, an intensive program of volunteer education has been mounted through the University of Iowa College of Medicine using carried over money from the Iowa Regional Medical Program.

(Please turn to page 332)

QUESTION BOX

(Continued from page 331)

How is the HSA different from its predecessors and will it do things better than previous mechanisms?

This is a most difficult question because we all perceive "different" and "better" in our own way. Certainly we will be different in that the Health Systems Agency encompasses a much larger area than the old Comprehensive Health Planning Councils. The HSA also has a very specific set of responsibilities as contrasted with the vaguely defined responsibilities of our predecessors. However, these differences will not make an appreciable impact on whether or not we do things "better" than in the past.

The new agency is required to have specific skills among its staff members and this was not a requirement of earlier organizations. And even though our current funding level is meager, it is proving adequate to attract well qualified, experienced staff with the requisite skills. If we can continue to maintain a high level of community involvement, I feel certain the increased size of staff with the accompanying diversification and sophistication of the staff's skills can produce a "better" planning effort than has been experienced in the past in most areas of Iowa.

As a relative newcomer to Iowa, what are your preliminary impressions of the health care system?

My initial impressions of the health care system in Iowa are basically good ones and I sense no more than our fair share of the problems that beset the national system. I have observed local physicians actively involving themselves with the planning process, I have participated with local physicians in a U. of I. College of Medicine retreat and from these activities the preliminary impression of an interested and concerned medical community is established. I have met with staffers from the IMS office welcoming me to Iowa and the managing editor of the IMS JOURNAL invited me to respond to these questions. This has conveyed the impression that the medical community is well organized and ready to assist in our planning activities. This is a good environment in which we can begin attacking the problems that exist.

★

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State Department of Health

ARBOVIRUS ENCEPHALITIS— DIAGNOSTIC CONSIDERATIONS

Summer and early fall are the times when cases of mosquito-borne encephalitis are observed in Iowa. Encephalitis and meningitis, caused by other viruses, are also common during this period. Although treatment is basically the same, i.e., supportive, arbovirus disease is amenable to control, providing adequate laboratory studies have been utilized to confirm the existence of a problem. With recognition of a problem, mosquito abatement activities may then be employed to interrupt the chain of transmission from the virus reservoir in nature to man.

In considering the diagnosis of arbovirus infection, clinical-epidemiologic factors should be kept in mind as well as laboratory values. A review of the subject follows:

Western Equine Encephalitis (WEE)—The WEE virus cycles between birds and *Culex tarsalis* mosquitoes with occasional spill-over into man and horses—both are dead-end hosts, i.e., any viremia that develops is too low to be picked up by feeding mosquitoes and transmitted to other animals. In Iowa, WEE in horses occurs every year in all areas of the state, indicating transmission potential is widespread. Confirmed human infections are infrequent and have averaged 1 case each 10 years in the state (except for 1975, when 5 cases of confirmed WEE were reported from Sioux City in Woodbury County). It is not certain what ecological barrier may account for this. All age groups are susceptible but the case fatality ratio is highest in elderly persons. Permanent neurologic sequelae occur most frequently in the pre-school age groups, particularly in children under 18 months of age.

St. Louis Encephalitis (SLE)—The SLE virus also cycles between birds and mosquitoes, with humans being incidental dead-end hosts. The principal vectors in Iowa are mosquitoes in the *Culex pipiens* complex, which live in close habitation with man and breed in foul, polluted water such as found in drainage ditches. SLE also affects persons of all ages with a high case fatality rate (10-20%) in the older age groups. During 1975, 19 cases of SLE were reported in Iowa; only 2 other cases were reported (in 1971) for the 15 year period 1960-1975.

California Encephalitis (CE)—This is Iowa's most frequently seen arthropod-borne viral disease, averaging 2-8 confirmed cases per year. Patients with CE tend to be concentrated in the heavily wooded northeast counties of the state, reflecting the distribution of the principal vector, *Aedes triseriatus*, or the "tree-hole mosquito" that breeds in the water that collects in basal tree holes. This species is found in other areas of the state where sporadic cases of CE are occasionally diagnosed. Unlike SLE and WEE, CE affects primarily children in the 5-9 year age group. Cases are rarely confirmed in persons over 16 years of age. A mild form of the disease is most common, although a severe form can occur resulting in personality or behavioral problems. Death is rare following CE infection.

Laboratory studies—the usual clinical laboratory can provide presumptive nonspecific evidence of viral encephalitis. Peripheral blood smears may show decreased WBC with relative lymphocytosis and cerebrospinal fluid might show pleocytosis and elevated protein, as observed in other viral infections. Laboratory studies for confirmation include virus isolation techniques and serology. Serologic determinations available from the State Hygienic Laboratory include complement-fixation, hemagglutination inhibition and serum neutralization tests. Paired acute and con-

valescent sera are necessary for a definitive determination. *Collection of a clotted blood specimen for serum early in the course of a disease is probably the single most important step in confirming a diagnosis.* Any patient with fever and headache plus any other evidence of CNS disease, such as meningeal irritation or other neurologic abnormalities, should have an early serum specimen collected and stored (frozen) for later study with a convalescent specimen. (Early specimens should be sent to the lab where they will be held pending submission of the second specimen.) If the state and local health departments are notified, they can provide assistance in collection of a second specimen.

Virus isolation is less commonly employed but should be attempted if circumstances favor collection and submission of specimens. In severely ill or fatal cases, brain biopsy or brain specimens at necropsy should be collected in addition to blood sera. *All specimens for isolation should be frozen immediately and kept in a frozen state during transport.* Please contact the State Hygienic Laboratory *in advance* for other specific instructions.

Viral isolation provides the possibility of a definitive diagnosis and unlike serology provides the possibility of confirming the diagnosis if other CNS viruses are involved i.e., enteroviruses, ECHO, etc.

For reporting suspect arboviral encephalitis cases and for assistance with diagnostic studies and other investigative efforts, immediately call:

1-800-362-2736 (Toll Free)
Disease Prevention Division
Iowa State Department of
Health

The Center for Disease Control in Atlanta, Georgia, is reviewing a system of definitions in classification of arthropod-borne encephalitis as follows:

"Confirmed"—Cases involve isolation of the virus from appropriate specimens, a four-fold rise in hemagglutination-inhibition or complement-fixation antibody titers of paired sera collected a week or more apart, or a hemagglutination-inhibition titer of around 1:640 in a single serum sample along with signs and symptoms compatible with arboviral encephalitis. Virus strains recovered are identified using known specific immune reagents in complement-fixation and neutralization tests.

"Probable"—Cases are associated with a hemagglutination-inhibition titer of 1:80 or greater or complement-fixation titer of 1:16 or greater, plus clinical manifestations.

"Suspect"—Cases involve lower titers, inconclusive laboratory tests, or an absence of laboratory data in the presence of clinical evidence of encephalitis or aseptic meningitis.

MEDICAL MISCELLANY

(Continued from page 329)

SOCIETY MEMBERSHIP . . . As of the end of June, physician membership in the Iowa Medical Society was 18 ahead of the same date in 1975. Iowa physicians belonging to the AMA were at nearly the same level as a year ago. Voluntary support of the Iowa Medical Political Action Committee (IMPAC) and the Scanlon Medical Foundation surpassed the preceding year by more than 100 physicians.

MAKES PRESENTATION . . . A representative of the AMA's relatively new Department of Negotiations presented information on this aspect of the AMA program to the IMS Executive Council July 29.

JOINT CONSIDERATION . . . Memoranda of understanding are being devised by the Iowa Medical Society and Iowa Foundation for Medical Care to cover IFMC nomination and fiscal procedures, as well as guidelines for third parties using Foundation services. The IMS Board has approved the intent of the memoranda and expects to finalize the language with the Foundation Board.

REAPPOINTED . . . C. L. Beye, M.D., Sioux City, has been reappointed to the State Board of Medical Examiners by Governor Robert Ray. Dr. Beye will serve another three-year term.

NEW GUIDELINES . . . The IMS Board of Trustees approved in June a set of guidelines for use in the conduct of its work. The Board consists of eight physicians and meets monthly.

Educationally Speaking

by RICHARD M. CAPLAN, M.D.

IN THE THICK OF THIN THINGS

So many people have the idea that continuing education is the learning of new facts! Yes, there are indeed new facts to learn, but also new skills. And also new attitudes. And then we must also take pains to unlearn or abandon inappropriate facts, skills or attitudes. Sometimes that's much more difficult than acquiring them in the first place.

But competence is so much more than just knowledge. In addition to knowledge, competence for the clinician includes abilities in gathering information . . . and skills in communicating, teaching and effectively persuading . . . and managing a complex biological-psychosocial equation of many variables after having analyzed and evaluated a total circumstance and made a judgment. And in truth, it's not just competence either that we want, but rather, competent *performance.* And performance is a composite of competence of the physician modified by a mesh of institutional or environmental conditions. That's why it's so important that physicians be active in assuming effective management of office affairs, hospital rules, and even governmental decrees. Those considerations that are external to our basic biomedical knowledge and clinical skills are crucial to effective performance of our role in caring for the ill or maintaining the health of the well.

One of the insidious failings of that compulsory continuing education that looks only at enrollment or attendance at a required number of educational hours, is that we as well as the public may be confused into thinking that the usual educational experiences that focus so heavily on facts (knowledge) are really what matter most. Most formal studies, however, suggest instead that attitudes, clinical judgments and actual performance most warrant our attention and remediation. Rather than measure hours of attendance at formal and accredited courses, we should be looking to measurement of physician behaviors and patient outcomes. We are likely missing the forest for the trees. Or to use a superb phrase of Dorothy Parker's, our concern for hours and accreditation puts us "in the thick of thin things."

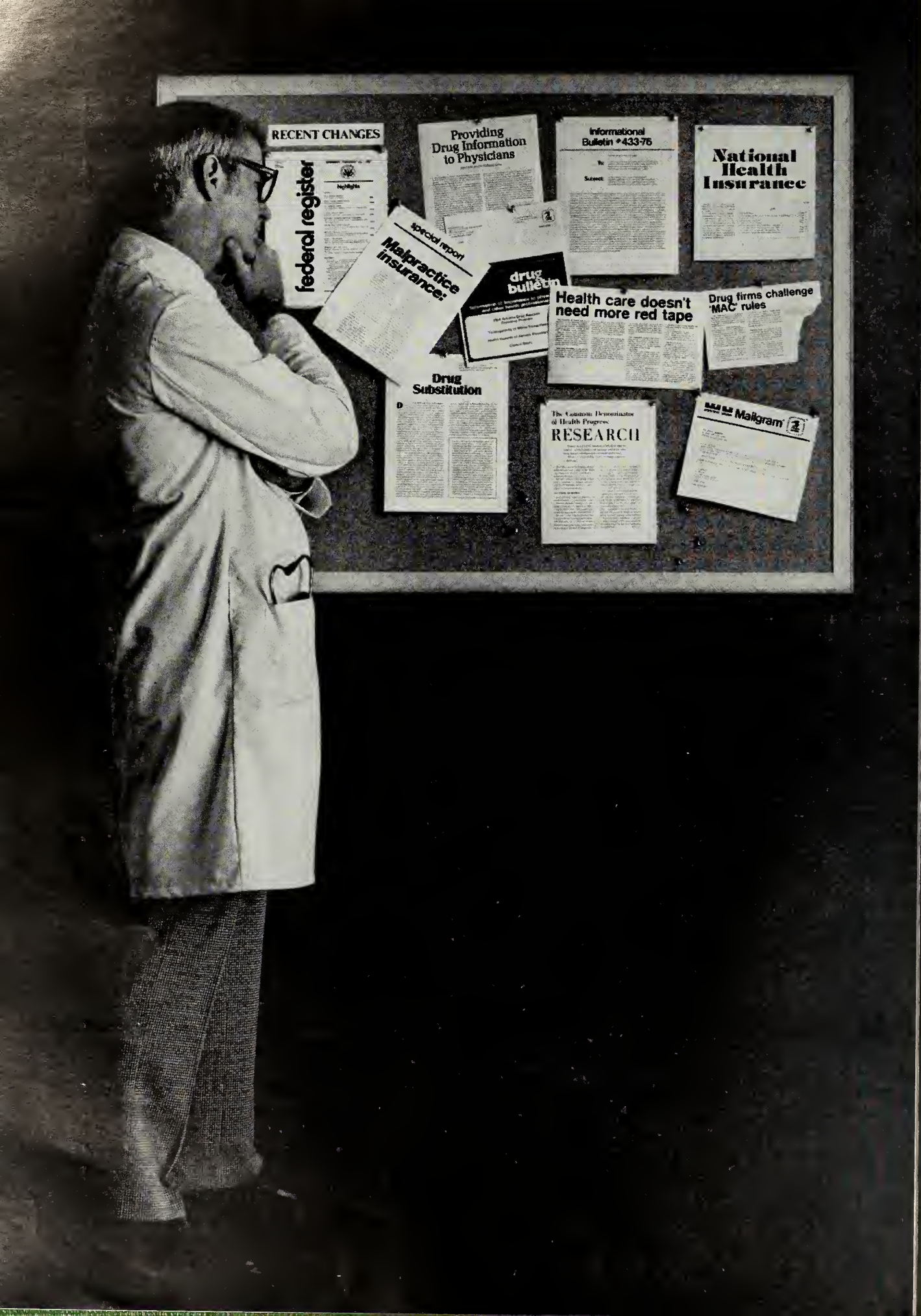
Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

SPECIAL CARDIOLOGY STUDY

A special training opportunity in pediatric cardiology for family physicians or pediatricians with some previous cardiology training has been announced by the University of Iowa Office of Continuing Medical Education and the Department of Pediatrics.

The program involves attendance on four separate days at cardiac field clinics of the State Services for Crippled Children, where large numbers of cardiac patients are seen. A fifth day will be spent in the pediatric cardiology unit at University Hospitals.

The total program is approved for 31 prescribed hours (AAFP) or 31 Category I hours (AMA). The fee is $250. Further information may be obtained from Richard M. Caplan, M.D., Office of Continuing Medical Education, University of Iowa College of Medicine, Iowa City, Iowa 52242.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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

COMMENTS ON A PHYSICIAN'S DEVOTION

The following Letter to the Editor appeared in the July 8, 1976 issue of the DES MOINES TRIBUNE. *It is reprinted here with the permission of its author, Mrs. Rutledge O. Schropp, the widow of a Des Moines surgeon. In her thoughtful comments, Mrs. Schropp describes the kind of committed and rigorous routine which her husband followed in the care of his patients. She places the overwhelming majority of the country's physicians in a similar highly dedicated status.*

I am often saddened by reading articles in THE REGISTER or TRIBUNE which portray doctors of medicine as blundering, heartless, moneymongers. The June 29 TRIBUNE feature, "Medical Mistakes," by Bard Lindeman, in which he reviewed a book, "Julia's Story," subtitled "The Tragedy of Unnecessary Death," by Fred C. Holt, triggered my writing in protest and defense of the hard-working, concerned men and women who make up the overwhelming majority of our country's physicians.

My father was a "doctor of the old school," a surgeon in Des Moines for more than 40 years. He has been dead for several years now, but many people will testify that they are alive and contributing today because of his skill and devotion.

My husband was also a surgeon. He died three years ago of a coronary. He was an active, athletic man of only 50 years. His life and practice were not exceptional, but similar to those of most doctors in his field in Des Moines. In the five weeks just prior to his death he had not had a single day away from his work, not even a Sunday. A "normal" 12-hour work day began at the hospital at 7 a.m., and got him home for dinner at about 7 p.m., but he usually went back to the hospital after dinner to check again on his most critical patients, and to catch up on the mountains of paperwork required these days of every doctor admitting patients to the hospital.

Perhaps he would get home, totally exhausted, by 10:30 p.m., hoping to rest until morning, but more often than not he would be called out to take care of an emergency, or at least have his sleep interrupted several times during the night by calls from nurses or interns requiring special instructions.

No one outside of the medical profession or members of a doctor's family can appreciate this pace, nor realize the worry and mental anguish that a conscientious doctor expends on the lives dependent on his knowledge and ability. And in the end, his many years of intensive and expensive training, his utmost skill, the most modern equipment and drugs, may all fail to prevent an infection unresponsive to treatment, a fatal embolism, or death from some other known or unknown source.

Death comes to everyone sooner or later. A good doctor does his best to prolong life and relieve pain, but he is not, nor does he pretend to be, God. Often, as evidenced by the untimely deaths in recent months of several of our finest Des Moines doctors, the more dedicated he is, the fewer years he will be physically able himself to serve a public quick to criticize.

I, too, share with Messrs. Holt and Lindeman the "trauma of losing a youthful" mate, but in this instance the "mistake" was my husband's choosing to be a conscientious and dedicated physician, giving to each patient a part of his own life. In the last analysis, this "mistake" must be re-judged as "right."—Mrs. Rutledge C. Schropp, 420 Fifty-first St., Des Moines.

IN THE PUBLIC INTEREST

SCIENTIFIC ARTICLES

Involutional Psychoses: Fact or Fiction?

SIDNEY L. SANDS, M.D.
Des Moines

Current interest in depression has led to a number of divergent systems of explanation for the clinical pictures encountered. In an effort to develop global concepts which might unify the various diagnostic categories, the author argues for preservation of distinct clinical entities which share certain common features. The Involutional Psychoses are discussed as a model for this thesis.

THE TREMENDOUS NUMBER of publications, in both professional and popular press, on depression attests to the widespread concern regarding this condition and its often tragic consequences. A comprehensive bibliography of even recent times would encompass many hundreds of titles from all the behavioral sciences. Many of the earlier journal articles tended to concern themselves with the psychopathology and dynamics of depressed states. More recent journals are oriented in genetic, biochemical, and chemotherapeutic investigations. This latter development has yielded significant information, but often has tended to obscure our understanding of the real nature of depressive reactions. This discussion will present a broader conceptual framework within which we may possibly clarify our perspectives on the whole subject. It is my intention to use the involutional psychoses as a model.

OVERVIEW

With the work of Freud,[1] Abraham,[2] and Rado,[3] the understanding of grief and mourning as psychological processes of adaptation came into focus. This provided new insights into the psychopathology of many depressed patients.

The contributions of these writers gained a high degree of credibility. Their theoretical formulations were grounded in an elegantly developed theory of personality and their sensitive observations characterized patients presenting a depressive syndrome. They paid careful attention to the life history of the individual and the conditions present at the onset of the acute disorder. It was with the elaboration of the dynamics of personality development that we came to understand the role of particular experiences as they contributed to the individual's strengths and weaknesses, his special sensitivities, and structured defenses. It was these that prepared the individual well, or not so well, to cope with particular stresses during particular periods of adult life. This provided a system of psychological explanation of normal and pathological depression. It was inevitable that efforts to generalize from the special problems of grief and mourning to all forms of depression would fall short of the goal. Despite attempts to devise a system of psychological explanation for manic-depressive disease and certain less well defined psychotic depressive reactions, too many cases lay beyond the reaches of these formulations.

More recently, many workers,[4-9] engaging in genetic studies and sophisticated laboratory in-

Dr. Sands is Professor of Psychiatry and Assistant Dean, College of Medicine, State University of Iowa, and Director of Psychiatric Services, Broadlawns Polk County Hospital, Des Moines, Iowa.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF AUGUST, 1976.

vestigation, have advanced a biochemical explanation of depression which does not require any special psychological theory to account for the observed behavior. While, in some instances, token recognition is given to the role of intercurrent stresses, little attention is paid to premorbid personality and its significance for the determination of individual therapeutic needs. The attractiveness of the biochemical approach is its physicalistic frame of reference which permits us to order our thinking within relatively finite boundaries and can reduce therapy to a series of physical, or chemical, treatments. The advantage of all of this is that in a large proportion of cases, so regarded and so treated, a symptomatic cure results in a relatively short time and with minimum involvement of the psychiatrist's time. The difficulty is not all depressed states are identical, either biochemically or psychologically, and the conscientious psychiatrist must be able to make discriminatory judgments to identify the multiple etiological factors which produce the depressive syndrome in each individual. It is only with that, a rational therapeutic program can be properly developed.

Thus, neither the biochemical, genetic, nor psychological explanation has sufficiently high descriptive power, or predictive potential, to warrant exclusive dominion in the discussion of depression. It would appear essential in all abnormal behavioral states to take cognizance of, and seek to identify, genetic, biochemical, constitutional, psychological, and social factors which produce the unique constellation of signs and symptoms necessary for understanding each patient. In the analysis of these factors, we can establish a rational basis for selection of the therapeutic modalities most likely to serve the needs of the patient. We must remain always mindful of the injunction to fit the therapy to the patient and not the patient to the therapy.

INVOLUTIONAL PSYCHOSES

In 1941, this author was privileged to work with Dr. William Malamud and his wife, Irene, at the Worcester State Hospital. We were interested in depressive phenomena and felt it should be possible to demonstrate psycho-social factors in the lives of certain patients which operated to precipitate the so-called involutional psychotic reactions. In the development of the original paper,[10] and a follow-up study published in 1941,[11] we became convinced our hypothesis was correct. Subsequently, a study done with Dr. David Rothschild,[12] concerned with reactions to aging, added conviction to our belief that involutional psychoses constituted a unique group of reactions which, at the same time, held much in common with many other depressive conditions. With the passage of time and the current resurgence of interest in depression as a clinical phenomenon, a re-examination of our earlier conclusions is merited and hopefully will identify certain unique features of the involutional psychoses, as well as a conceptual basis, for an approach to all depressive reactions.

A. *Age of Onset*—In the life span of all individuals there are generally certain periods where vulnerability to particular stresses is critical. The age span from 45 to 65 appears to be such a period. The study of many personal histories reveals that major depressive, or paranoid reactions, can occur at this time without evidence of any prior serious behavioral disorder. It is interesting many current movies and plays depict the special problems of life in this period. Why is this so sensitive a time? It is a period of change involving biological, psychological, and social elements which, in various combinations, can prove distressing to most people and which can combine to produce that syndrome which we call involutional psychoses in particular individuals.

B. *Biological Factors*—Whatever dynamic psychology and personality theories may have contributed to our understanding of human behavior, a large number of investigators have viewed behavior in the context of genetics, biochemistry and neurophysiology. Their work has influenced many clinical psychiatrists to adopt the so-called "organic point of view." It was in the conduct of certain research activities in affiliation with the Worcester Foundation for Experimental Biology that Rodnick and I[13] pointed up the difficulties of explaining motives, intentions, feelings, ideas, and values in physical terms and that lacking epistemic correlations, great caution must be taken in attributing complex behavioral sequences to particular organic abnormalities.

In this context, we give serious attention to the contributions of the physical sciences to the understanding of behavioral phenomena, but we must be cautious in attributing etiological significance to physical factors whose role cannot be clearly demonstrated. Statistical correlation does not explain relationships. Baldasserini[14] discusses in detail the strengths and weaknesses of the "amine

hypothesis" in affective disorders and McCabe[15] presents strong evidence to support the concept of "reactive psychoses." Nevertheless, it is possible to identify some biological factors whose influence can be fairly well defined and can be correlated with behavioral reactions.

Among the organic factors to be considered, aging, as a biological process, certainly must be reckoned with. Aging, per se, varies from individual to individual, both in rate of change and in its special manifestations. Families differ as do individuals in the patterns and time of disturbance of organ function and in cellular change. Some people are biologically old at 45 and others, despite appearance, may remain vigorous, productive, and intellectually efficient into much later years. Genetic factors interacting with incidental and accidental health factors can impair physiological efficiency and reduce adaptational ability. Equally important is what these changes mean to the individual. Our perception of changes and the meanings we attach to them can seriously alter our attitudes, values and techniques of coping with our feelings and with life. Pre-existing anxieties about aging can become reinforced and over-determined by the appearance of even quite normal changes, such as loss of hair, the appearance of wrinkles, weight gain, and modest decline in energy and libido.

The small aches and discomforts associated with age-induced changes in gastrointestinal function and neuromuscular coordination further encumber the picture. In women, menopausal distress, or other pelvic problems, can become focal points of intense concern. In males, prostate pathology with its attending discomforts and possible surgery can induce profound emotional reactions. For many, these may be fairly normal and transitory reactions which do not lead to a serious breakdown in social and psychological adaptation. For others, these become the alarm signals which warn of potentially disastrous emotional crises and development of a psychotic reaction. In earlier studies[10, 11] we found that pelvic, or abdominal, surgery at this time of life did, in certain cases, precipitate psychotic-depressive reactions. The development of angina, especially in males, often led to debilitating anxieties, not infrequently accompanied by depression. In these instances, the combination of normal aging, plus the added burden of age-related medical, or surgical, problems was seen to induce a depressed and anxious state. However, these, in themselves generally do not tend to cause reactions of psychotic proportions. Winokur and others,[4, 5] have provided detailed evidence of familial patterns highly suggestive of genetic predispositions to depressive reactions. These seem to relate to disorders of catecholamine metabolism and aging patterns which appear to be more meaningful in the clinical pictures associated with the manic-depressive reactions, or variants thereof. Nevertheless, their findings compel us to recognize that genetic factors may well be involved in some degree in many depressive states and, while these may play a role even in the involutional group, the evidence is somewhat less than convincing for this condition. At any event, aging and problems arising from illness, or trauma, can operate as particular etiological agents which have a special predilection for individuals in the age period 45 to 65.

C. Psycho-Social Factors—For individuals in the age period 45 to 65, many significant changes tend to occur in their personal lives. While the same kinds of events might possibly occur at earlier times, their significance becomes enhanced by virtue of the special psychological conditions. It is my belief that events which tend to be commonplace among people in this age period have unique physiological, psychological, and social significance.

(1) *Parents:* People in the age group just designated have, by this time, often lost one, or both, parents or, if living, the parents are now elderly and require certain supports from their adult children. In a sense, this reverses the earlier child/parent dependency relationships. As will be discussed later in the paper, these conditions pose special problems for certain individuals. Not only do we at this time of life experience the loss of parents, but we have also reached a point where other family members and friends have succumbed to the stresses of life. All of these losses sensitize us to a sharpened awareness of our own mortality and, for particular people, they attach special meaning to these experiences and they become particularly vulnerable.

(2) *Children:* This is the time when children have left the nest and are likely preoccupied with their own careers and growing families. Oftentimes they are separated from us geographically. In this period, we are prone to become a bit more sensitive to real, or imagined, evidence of neglect or lack of interest on the part of our children. The quality of the relationships we have with our children at this time of life can operate as a critical factor in qualifying our attitudes and feelings about ourselves and about life. Those individ-

uals who may be childless tend to become more sensitively aware of the lack of "closeness" to those sources of love, respect, and support ordinarily associated with a sense of family.

(3) *Work:* In this age group, careers have been quite well set and the likelihood of meaningful advancement is already diminished. In many situations, individuals have reached their top occupationally and are compelled to face the prospect of challenge from younger colleagues and the looming possibility of enforced retirement. In many jobs, pressure to produce continues and in those instances where there is little real satisfaction inherent in the tasks of the daily routine and where there is a remaining necessity, economically, for staying on the job, the generated tensions take their toll physically and psychologically. The non-working woman who has reached a point where her children are functioning independently may find her homemaking activities have become an unrewarding routine and she is frustrated by the emptiness of meaningless social activities.

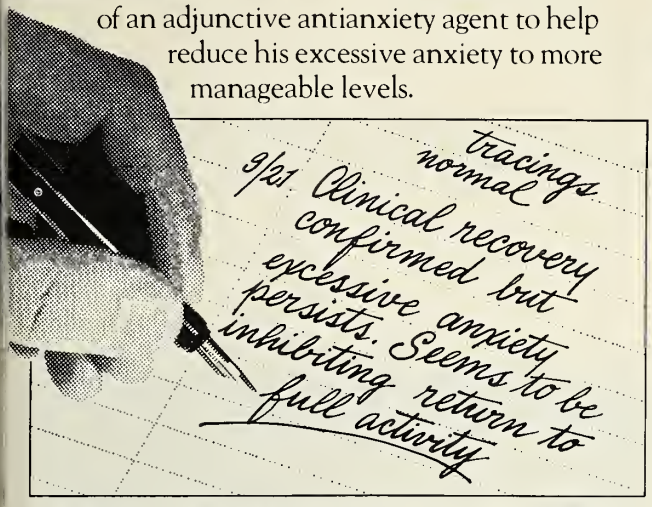
(4) *Marriage:* In my own book on marriage[12] I have expressed concern for the stresses occurring during the middle and early late years of a marriage. Assuming the ordinary statistics to prevail, most people in this age period are married and many have been for a long period of time, whether in single or multiple marriage careers. Personal habits and individual eccentricities, which were once easily accepted by the mate, may now be viewed as sources of irritation. Familiar routines and relationships may now seem monotonous and unexciting. For many, awareness of boredom and tension may lead to extra-curricular involvements in a somewhat pathetic effort to recapture a disappearing youthfulness. These can be difficult years for many marriages and the institution, itself, becomes increasingly vulnerable to the varied stresses of life unique to this period. Aside from these types of difficulties, illness or disability due to injury in one of the partners adds additional stress to the relationship, sharpens our awareness of increasing dependency, limits our activities, and subjects the mate to the possibility of further decline and demise. Unique problems attendant with prolonged illness add to the burdens and enhance our frustrations and anxieties.

(5) *Socio-Economic Factors:* In this area, the behavioral scientist must take into account a complex system of variables operating in the environment which can profoundly affect the psychological state of the organism. For human beings, this involves not only the physical qualities of the life space they occupy, but many more abstract and subtly pervasive elements to which the individual reacts in a highly personal manner and to which he assigns his personal meanings. These, in turn, influence attitudes and values which powerfully affect the adaptational techniques and emotional state of the individual. In a more global frame of reference, the economic and political climate in which we live creates conditions which have a general effect upon society but also rather special effects on selected segments of the population. To be young and unemployed is different than to be 50 and to experience job loss at that time. To be on a pension during periods of economic inflation and recession is different than to be drawing a salary keyed to cost-of-living adjustments. To live in the inner-city is different than to live in the suburbs. To be black is different than being white. To be educated is different than being uneducated in a technological society. All of these, and many other social conditions, constitute stresses for us all. How well we cope with them is a function of the quality and quantity of the stresses and the strengths and weaknesses of the given individual as determined by the premorbid personality.

D. *Premorbid Personality*—We now come to a most crucial element in our discussion of the involutional psychoses—the personality of the individual who develops such a disorder. The biogenetic factors, the early life experiences, the level of social achievement attained, our successes and failures all shape what we generally refer to as the personality of the individual and it is this which determines how well, or how poorly, we will cope with the "slings and arrows of outrageous fortune" at various times in our lives. Not everybody breaks down in the presence of stress. We are not all equally subjected to the same stresses, yet every human has his breaking point. Who then does break and under what conditions of life does this tend to occur? In our earlier work[9, 10] we were impressed by the presence of certain characteristics of the premorbid personality which rendered these individuals especially vulnerable to the stresses peculiar for the age period 45 to 65. Conversely, we also found that fortuitous circumstances of life could protect those who are vulnerable and enable them successfully to survive the rigors of the involutional period.

(Please turn to page 343)

patient's ability to participate fully in his rehabilitation program, your counseling and reassurance are often sufficient. But when his anxiety is so great that it actually interferes with his ability to listen and respond, you may want to consider the addition of an adjunctive antianxiety agent to help reduce his excessive anxiety to more manageable levels.



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*Zohman BL: *Geriatrics* 28:110-119, Feb 1973

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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THE ANXIETY-SPECIFIC

VISUAL FOCUS ON ACUTE GOUTY ARTHRITIS

Foot of patient with acute gouty arthritis as seen by conventional x-ray.

Scintiphotogram of same foot reflects inflammatory process.

The scintiphotograph on the right shows increased uptake of radiotechnetium polyphosphate in the metatarsophalangeal joint and the proximal interphalangeal joint of the great toe of a patient with acute gouty arthritis. This increased uptake probably results from increased vascularity in the affected areas.

For a more detailed description of scintiphotography, see "addendum" at right.

(Continued from page 342)

Since these original studies were done, we have had no reason to change our first impressions and we remain more convinced than ever of the applicability of our conclusions. In the course of our studies, two rather distinct types of personality were identified for high-risk for the development of involutional psychosis. One may be described as being extremely *dependent,* often in a passive/aggressive anaclitic manner. The second type may be described as extremely *independent,* often in an active/aggressive, driving, success-oriented manner. Both share certain more subtle, but basic and important, psychological characteristics. They tend to be ego-centered and ambivalent in their object relationships. Depending upon the special circumstances of early life, and the degree to which they acquired the ability to master stimuli, the personality could develop in either direction and, characteristically, both tend to develop patterns of coping techniques early in life which become rigidly structured and difficult to modify. Yet, both types of personality can escape psychological breakdown prior to the involutional period *if* their individual life situations accept and support their special qualities of behavior. Let us examine each in more detail.

(1) *The Dependent Personality:* Throughout their lives, these people have been able to lean upon others for support. In some instances, this has been fostered by over-solicitous and over-protective parents. In other cases, personal limitations, either psychological or physiological, have made it necessary for the parents to give extra support and protection. Depending upon the psychological setting of the home, they may learn a variety of techniques to compel others to serve their needs. The secondary gains from illness are quickly discovered. When such people are successful in establishing acceptance of their dependency, they experience relatively little distress. However, they are very sensitive to disappointments and their ambivalence and egocentrism becomes easily demonstrated. Inwardly, they are often embittered by their dependency and use a variety of neurotic, and/or acting-out, reactions to justify their position. They learn the use of tears, or of helplessness, to gain attention and support from others. They learn not only how to arouse sympathy, but how to make others feel guilty in the relationship. To the degree they succeed with this, they maintain their stability, and rarely decompensate seriously. However, by the time they are 45 and older, chances are that parents are either gone, or are much less able to give the support that is demanded. The husband, or wife, of such an individual may have died, become incapacitated for reasons of health, or have lost interest and concern for the mate. Children, accustomed to the ways of the individual, have often learned to detach themselves and have grown aloof and unresponsive in reaction to the patient. Friends, who were previously sympathetic, may have become disinterested, or may even abandon the patient. Social agencies, which may have been involved in the patient's life, may, at this time, have given up all efforts to meet their unceasing demands.

In short, it is at this time when the familiar forces of support may well have been withdrawn. In most instances, we tend to find a significant loss, such as the death of a close relative or friend, serves as a precipitating factor in the production of a major depressive reaction. Less obviously, we find instances where a forced move from a familiar homesite, financial loss, or even pelvic surgery may act as a last straw and result in an agitated depression typical for the involutional psychotic group.

(2) *The Independent Personality:* In contrast to the dependent personality, these individuals rather easily survive the loss of relatives or friends and they do not experience grief with the usual intensity. They have learned to detach themselves from deep human involvements and they do not experience emotional crisis in the presence of loss early in their lives. For them, the critical losses are those associated with alterations within themselves. It is when their own abilities begin to decline or when the aggressive exercise of their own ambitions cause them to be ousted from a position of authority that the resulting loss of self-esteem can become critical. They tolerate physical illness or injury poorly, both of which impose restrictions on their physical activities. It is difficult for them to relinquish their domination of others and they resent challenges to their authority. Awareness of declining energy, or efficiency, or of threats to their authority may lead to excessive effort to compensate, resulting often in chronic tension and increasing conflicts with those around them. If their health breaks down, or if they are demoted or pushed into early retirement, a serious depression may result.

E. *Psychopathology*—The classical descriptions of the involutional psychoses generally deal with the phenomena of an agitated depression associ-

ated with florid feelings of guilt, often delusional in nature, self-deprecation, with intropunitive aggression and suicidal drive. There is little need to elaborate on these phenomena at this time. For detailed descriptions, the reader is referred to representative works such as Grinker's[16] and Lesse.[17]

More recently, a number of investigators have challenged both the dynamics and phenomenology previously ascribed to the involutional psychoses. Some believe that they are either variants of manic-depressive disease or are true endogenous depressions arising from altered states of catecholamine metabolism associated with some form of genetic pre-disposition. It is not likely that any one system of explanation suffices to account for the full range of depressive states which can be found in our populations of patients. It is more likely that multiple factors play an etiological role and that the personality of the patient is a central element in all reactions.

It is interesting that not all cases of involutional psychosis present with a florid agitated depression. Current nosology also recognizes an involutional paranoid reaction. In these instances, we tend to find the same type of basic personality structure but, in addition, these individuals have in their premorbid personality evidence of a prior paranoid attitudinal orientation. When, in the course of the involutional period, these individuals experience significant losses, and ego defenses are breached, paranoid delusions may develop. The reason we see little evidence of depression in these cases is because the delusions bind the depression very much as hysterical conversions bind anxiety. Bleuler,[18] in his discussion of the schizophrenic, recognized that delusions and hallucinations serve as defenses to protect the individual from being overwhelmed by the disintegrating effects of excessive and painful emotions. It is this author's belief that the paranoid delusions in the reaction serve to attenuate the devastating effects of the feelings of depression which, in so many instances, can lead to self-destruction. In our earlier studies and in subsequent clinical experiences, we found the histories of these patients rarely indicated any prior psychotic episodes, or true paranoid states, and we believe this is to be explained on the basis of the personality and dynamics previously noted.

TREATMENT

The efficacy of electroconvulsive treatment for various depressive states tended, for many years, to encourage the widespread use thereof in the majority of affective disorders. With the development of anti-depressive medications, more and more patients are being successfully treated without recourse to "shock" therapy. Time and experience has permitted us to become more selective and discriminating in our choices of treatment modalities so that most psychiatrists have formulated criteria whereby they can use them singly, in combination, or ad seriatum depending upon patient response.

Earlier efforts at different types of psychotherapy alone in the treatment of serious depression prove to be almost fruitless. Whatever the beauty and logic of psycho-analytic explanations of depression might be, psychoanalysis has, rarely, been effective in the treatment of these disorders. However, it would be poor medicine indeed and poor psychiatry if our therapeutic endeavors were to be limited to strictly physical-chemical modalities. Nor is it sufficient that the treating physician, using such, content himself with merely providing "supportive" psychotherapy in the form of reassurance and opportunity for ventilation.

We must be reminded of the admonitions of Plato, as expressed in the dialogue, *Charmides*,[19] "that as you ought not to attempt to cure the eyes without the head, nor the head without the eyes, so neither ought you attempt to cure the body without the soul." In the instance of the involutional psychoses, we must never allow the diagnosis, dominated as it may be by the gross picture of an agitated depression, or paranoid behavioral reaction, to obscure our awareness of the premorbid personality and its implications for the post-treatment adjustment of the patient. At some point in the clinical course, the physician must inform himself of those elements in the personal history which define the patient's strengths and weaknesses as a human being, and he must be prepared to offer the patient a combination of therapeutic supports which may be appropriate at each stage in the course of treatment. This must include a program of followup care designed to meet the particular needs of each patient. The total treatment regimen requires that we take cognizance of existing medical problems and their treatment. It must involve the early establishment of a trusting relationship with the patient and the early institution of appropriate chemo- and/or ECT, as the indications dictate. Regular visits with the patient must be maintained to facilitate the on-going relationship and to enable the

(Please turn to page 350)

The Sideline Bag

PETER D. WIRTZ, M.D., and
LONNIE CLARK, R.P.T.
Des Moines

With the start of a school year near at hand, sports competition will return to full swing with the football season. Caring for injuries at athletic events requires certain special equipment. This short article offers a few tips on what should be included in the sideline bag.

THERE ARE CERTAIN items necessary for emergency athletic care which should be placed in the physician's or trainer's sideline bag. A review of these items may be helpful at the start of a new school year. In addition to the bag itself, support items such as stretchers, back boards for spinal injuries, ice, local anesthetics and suture material should be nearby or in the school training room.

The sideline bag itself may be a medical bag. Or it can be any container, such as a fishing tackle box, with multiple divided areas for small objects. The bag should be organized and arranged so that emergency items are readily identified as soon as the bag is opened. It is essential to keep the bag replenished from week to week so that a needed item is not missing when an emergency arises.

In order to remove the football face mask without further damaging a neck injury, a double action bolt cutter is needed in the sideline bag. This kind of device is often a forgotten item.

To promote emergency care for an airway an oral screw should be provided to open a locked jaw. Varying sizes of oral airways should be placed in the bag, or a universal airway for adults and children can be included. A padded tongue blade is helpful in these situations and also with seizure problems. A disposable laryngoscope with a light source is valuable when an endotracheal tube is needed for breathing assistance until the patient can be moved. An Ambu bag will be necessary for assistance with an endotracheal tube. A large syringe (50 cc) and a catheter are excellent for oral suction if such is needed.

Airway obstruction or tracheal trauma may require cricothyreotomy or tracheotomy. Such emergency care is difficult to provide out of a hospital setting, so it is advisable to have multiple 13 gauge needles to be inserted into the cricothyroid to temporize airway obstruction until the athlete can be moved to a hospital.

A small pen light is useful for oral, nasal and eye examinations.

Medications that require syringes and varying needle sizes include epinephrine, 2 ml, 1 : 10,000, for cardiac arrest; Valium, 20 mg for seizure problems; and Decadron, 4 mg for head or spinal cord injuries.

Eye irrigating solutions and patches are necessary for foreign bodies.

Air splints for upper and lower extremity injuries are easy to pack into a bag and afford excellent immobilization. Small aluminum splints and tape are needed for finger and hand injuries. A triangle sling is all that is necessary for many upper extremity injuries.

Lacerations are best treated with sterile dressings and pressure until they can be cared for in an emergency department. A scissors kit is beneficial for blister and torn finger nail removal, while a ring cutter is an extremely valuable instrument if a finger has a distal injury that blocks ring removal. Epistaxis is easily controlled on the field by placing a dental roll or similar padding in the external nares.

A small notebook is very useful for documenting emergency treatment and may be referred to

Dr. Wirtz is in the private practice of orthopedic surgery in Des Moines and serves as team physician at Drake University. Mr. Clark is assistant trainer at Drake University and is a certified athletic trainer.

when a report is prepared for those who provide the athlete with follow-up care.

These suggestions are offered to stimulate the thinking of those physicians and trainers who cover athletic events in Iowa. Actually, the sideline bag should be tailored to the particular needs of the individual using it and to the particular needs of the sporting event.

Cytology and Survival of Iowa Women With Cancer of the Cervix

JOHN W. BERG, M.D.
Iowa City

This review of all 1969 cervix cancer cases seen in Iowa shows: (1) Invasive cancer is diagnosed earlier than reported elsewhere: 76% instead of only 46% was localized. (2) The 5-year survival was 69% instead of 56%, only because of the earlier stage. (3) 5-year relative survival ranged from 95% for women in their 20's down to 60% for women in their 60's because, and only because, older women had so few of their cancers detected by cytology. (4) Differences in cytology detection rates for invasive cancer also accounted for 3-fold differences in survival rates seen in different areas of Iowa.

THIS IS THE SECOND in a series of Iowa cancer reports which analyze the 5-year survival rates for all patients diagnosed in the state in 1969. Details of the methodology may be found in the first report. In 1969, 719 cervical cancer cases were diagnosed in the state. Of these 448 were described as in situ cancers, 271 as invasive (including microinvasion). Ten percent of the invasive cancers were adenocarcinomas. While we had stage data of sorts on almost all cases, it usually was of the "localized," "regional," "distant" type rather than the much more useful standard gynecological scheme. The lack of detailed staging was particularly felt when we attempted to compare treatments.

All microinvasive cancers had some sort of surgery and no patient died of cancer in the first 3 years. (Two did die of their cancers between 3 and 5 years.) Almost all patients who were thought to have regional spread were treated by combined radiation; their 3-year survival was 50%. In international stages Ib and II, there were 31 patients receiving only surgical treatment (3-year survival 100%), 90 patients receiving only radiation (3-year survival 77%), and 13 patients receiving both modalities (3-year survival 92%). Before one could say that surgery actually was better, we would have to know whether most surgically treated cases actually were not stage Ib and most irradiated cases, stage II. Similarly, absence of detailed stage precludes us from saying anything meaningful about patient load and survival even though patients with stage Ib-II had a 3-year survival rate of 55% in hospitals treating only 1-2 cases/year compared to 85% in other hospitals.

The crude stage data may be compared with other series. The reports of the End Results Group are usually held to provide the U. S. standard. They reported for 1965-1969 that the stage of 46% of invasive cervical cancers was localized, 43% regional, 11% distant. Iowa cases

Dr. Berg is director of the Iowa Cancer Epidemiology Research Center and is associated with the Iowa State Cancer Registry.

TABLE I

AGE AND OTHER CHARACTERISTICS OF CERVICAL CANCER PATIENTS—IOWA 1969

Age	Cases	Detected by Cytology[1] %	Av. Stage Score[2]	Relative 3-year Survival[3] %
20-	22	58	2.4	95
30-	41	46	3.0	80
40-	72	30	3.3	78
50-	47	23	3.4	70
60-	45	15	3.9	65
70-	38	30	3.8	68
80+	9	0	4.0	22
All	274	31	3.4	73

1. Others detected by symptoms or on physical examination. %'s only from the 156 cases with information.
2. Based on a 1, 3, 5, 7 scoring system.
3. Cancer deaths only counted.

were 76% localized, 17% regional, 7% distant. Because of this, the 5-year survival was 69% instead of the 56% reported by the ERG even though stage for stage the survival rates were the same or slightly in the ERG group's favor. (Our stage distribution for both breast and cervical cancer is very like that reported from Utah and the likelihood is that the ERG cases are not typical.)

It is an accepted fact that older women with cervix cancer do badly. In Iowa, in 1969, the cervical cancer mortality rate for women in their 80's was essentially equal to the incidence rate. The table indicates how survival dropped with age in the study cohort. In general this could be attributed to the more advanced stage of older patients when seen. This in turn was associated with detection by symptoms, not by cytology. In fact cytology detection appears to account for almost the entire survival differential. Symptomatic patients under 50 had a 61% 3-year survival rate, older patients a 60% rate. For patients whose invasive cancers were detected by cytology the 3-year survival rate was 97% if they were under 50, 91% if they were older. Overall the 3-year *mortality* for symptomatic cancer was 10 times that for cytology-detected cases.

Differences in cytology detection also accounted for differences in survival in different parts of Iowa. Cytology most often was reported as the method of diagnosis in Cerro Gordo and Linn counties and these counties had the lowest cervical cancer mortality of any urban counties. Similarly, the rural counties around these two cities had the highest use of cytology of rural areas and the best survival rates. Combining related urban and rural regions, the 1969 invasive cervical cancer patients from the two best areas had only ⅓ the 3-year cancer mortality seen in the one region with no reported case detected.

A Word About the Iowa State Cancer Registry

The obvious duty of the State Registry is to follow-up on these findings by monitoring what we assume is the increasing use of cytology and by gathering more detailed information on stage so better correlations can be established between treatments and survival. Our failure to have done this emphasizes the tremendous inertial forces in a large data gathering system. The Registry was not empowered to study any factors relating to detection, stage or treatment in 1970 and 1971. Only the crudest treatment and stage data were asked for when data collection resumed in 1973, and the questions raised by this study cannot lead to a change in the system until we begin collection of 1976 data this fall. Of course, we could organize a reabstracting of earlier cases if there were interest in our doing so. In fact, the ideal situation for the Registry would be to have interested, knowledgable individuals and groups planning and analyzing all of our detailed data collections. The Registry is a tool, and like any other tool, what it produces depends mostly on the skill of the artisan. We invite and hope for your use of our system.—JOHN W. BERG, M.D.

Highlights of New Pharmacy Law

Physicians, pharmacists and patients now have a slightly different set of circumstances to understand and follow as they prescribe, dispense and obtain medications. These modifications in prescription handling became effective July 1, 1976 as a consequence of House File 200 which was passed by the 66th Iowa General Assembly.

Under the new law, pharmacists are authorized to provide alternate bioequivalent medications when no stipulation to the contrary is made by the prescribing physician. The law says it this way:

"If a physician, dentist, podiatrist or veterinarian prescribes, either in writing or orally, a drug by its brand or trade name and does not specifically state that only that designated brand or trade name drug product is to be dispensed, and if the pharmacy to which the prescription is presented or communicated has in stock one or more other drug products with the same generic name and demonstrated bioavailability as the one prescribed, the pharmacist may exercise his or her professional judgment in the economic interest of the patient or the patient's adult representative who is purchasing the prescription by selecting a drug product generically equivalent to but of lesser cost than the one prescribed for dispensing and sale to the patient."

When a substitution is made by the pharmacist he is obliged by law to inform the patient of the savings between the drug prescribed and the drug substituted.

The new law sets forth several instances where the pharmacist is precluded from making an alternate selection of medication. This occurs when (a) the prescriber (physician) so states; (b) when the person presenting the prescription indicates he or she wants only the specific drug product prescribed; or (c) when the drug product to be dispensed is listed on a nonequivalent drug product list called for in the law.

Item (b) above is not applicable when the prescription is to be paid for from public funds such as Medicaid. Here it is required that the lowest cost quality medication be provided. Item (c) assigns the Board of Pharmacy to develop within six months a list "of those drugs or drug products which have been demonstrated as being nonequivalent and are not interchangeable as determined by the Food and Drug Administration. The board shall mail a copy of the nonequivalent drug or drug product list to each pharmacy registered with it and each physician, dentist, podiatrist and veterinarian licensed in the state."

What is important for the Iowa physician to know and remember is this:

(1) If it is desired that the prescription given to the patient be filled exactly as written—with no consideration of an equivalent substitution—a reference to this effect should appear on the prescription. This may be done in any of several ways: (a) through use of a preprinted phrase on the prescription blank reading, for example, "Dispense as Written," or "No Substitution Permitted," with or without a box to be checked, or (b) by actually handwriting a statement to this effect.

(2) The physician retains full control over the medication to be dispensed. His means of assuring this are several-fold. It is mainly a matter of working with the pharmacist(s) serving the community to be sure there is an understanding of the procedures being used.

CANCER SCREENING

Support for "Cancer Screening Demonstration Programs" is available to members of the Iowa Medical Society from the American Cancer Society, Iowa Division. This support program of the Iowa Division of ACS is part of a total effort to encourage the concept of early cancer detection.

IMS members interested in instituting a local cancer screening detection program may obtain additional information by contacting Arthur F. Stocks, executive vice president, American Cancer Society, Iowa Division, Inc., P.O. Box 980, Mason City, Iowa 50401. (Telephone—515/423-0712)

The Iowa Division is willing to provide financial, statistical, volunteer and pre-project educational support for local demonstration programs which are authorized.

Editorials

M. E. ALBERTS, M.D., Scientific Editor

MEDICAL STAFF RESPONSIBILITIES

There are increasing numbers of physicians who receive direct remuneration from hospitals for activities which were once a part of their staff responsibilities. The massive impact of government on health care delivery has greatly increased the time and labor demands upon key members of the medical staff. Prior to this new age of medical practice, staff administrative responsibilities were less time-consuming, and often only honorary in nature. The president of the medical staff attended a few meetings, occasionally became involved with liaison between an errant staff member and the administrator, and presented greetings from the medical staff to the graduating student nurses. Now many programs dictated by federal laws and regulations require much study, time, and action by staff officers and committee members.

The responsibilities placed upon some staff officers are time-consuming and at the expense of the physician's practice. Meetings are often convened during routine working hours with members of the administration and non-medical persons on the board of directors continuing to receive their salaries. Yet, the physician must cancel appointments, juggle his office schedule, and continue to pay the overhead expenses while receiving no income. Service to the community is a great thing, but it should not always be a one-way affair.

There has evolved in some hospitals a method of partial remuneration to the medical staff members who assume responsibilities for the operation of the hospital. Some hospitals place the president of the medical staff on a salary during his tenure. The monies for this salary may come entirely from administration sources, or part from staff dues. Physicians on audit and utilization committees are often paid for their time on an hourly basis. These duties are necessary for the hospital to maintain accreditation. However, there are inroads being made in other areas which should be of some concern.

We should take a hard look at the appointment of various department chiefs wherein the hospital hires the physician to serve the hospital and ostensibly the medical staff. Some hospitals are considering full-time section chiefs. There is a trend in specialized hospital areas to have a salaried chief who dictates to a certain extent the workup of that department—directors of medical services, directors of continuing medical education, directors of resident trainees, as well as the departments of emergency care, intensive care, coronary care, neonatal care, and others. These persons are provided remuneration by the hospital, but are supposedly responsible to the medical staff. Yet, logic would dictate that the wise director more carefully watches the hand that feeds him. In the area of the training of the resident staff the director develops the programs, outlines the curriculum, and the non-salaried staff physicians often do the bulk of the teaching. If this trend progresses to the chiefs of the various sections of the medical staff, the results may be horrendous. The members of the medical staff could become peons with their identity lost in the organization maze.

Where does all this lead us; what are we to do about these trends? The privilege of being a member of a hospital staff carries with it definite responsibilities which we should be happy to bear, but when the affairs of the hospital encroach upon the physician's time too greatly some new approach must be developed. If the burden becomes costly, remuneration may be necessary. If much of the committee work is to fulfill Fed-

eral requirements, there should be some relief to the hospital budget through government funds. Staff funds must be expended as well because often it is a matter of a few persons doing a job for many. Those who do not provide their talent actively must be expected to pay for their freedom and inactivity. If the hospitals provide more and more fiscal recompense for the working members of the medical staff, we physicians cannot complain when the administrators assume more control. That, of course, is nothing more than good business function. Look hard at the trends. Become involved in the workings of the hospital medical staff responsibilities. Help plan for the future lest it all be planned for you.—M.E.A.

INVOLUTIONAL PSYCHOSES

(Continued from page 344)

physician to move the patient into new modes of therapy. Occupational, recreational, and social therapy activities can be gradually introduced as the depression begins to recede, or the paranoid delusions fade.

In the course of these activities, the physician can gain valuable information regarding the patient's coping ability, interests, and skills. He can also identify weaknesses to be dealt with and aptitudes to be developed. In concert with the clinical program, the physician may enlist the aid of the social worker to begin formulating a program of after-care. This must go beyond the patient to include preparing the family for the return of the patient and the selection of community resources whose services may be utilized by the patient. As the patient moves toward the time for release from the hospital, he, or she, should be informed of the general plan and, hopefully, be led to awareness of the objectives of such a program in order to see the future as providing the opportunity for a new, more satisfying, and happier life style. The physician will, of course, arrange for continuing office, or clinic, contacts. These will permit control of medications, but, more importantly, the patient will be better able to deal with personal problems, past, present, and future, in the context of an on-going program of psychotherapy. These office, or clinic, visits may be weekly at first, then as soon as practicable, they may be gradually spaced to once monthly, until the evidence of improvement permits first, termination of medications and, later, the visits themselves. Throughout this phase of treatment, the physician must keep himself informed of the patient's progress as seen by the family and those agencies working with the patient. This should be done with full knowledge of the patient so there will be no recriminations, or paranoid reactions. At the time of termination, the patient should be made to feel free to return to the physician whenever the need arises to "talk," or because the patient senses returning depressive feelings. It is in the context of this doctor/patient relationship that their dependency needs can be met, *but* in a new and healthier mode and for those patients who have previously been unable to accept dependency, this relationship permits them to do so without loss of self-esteem and with greater flexibility in relationships with others.

CONCLUSIONS

In our conception of all behavior disorders, we must see them as struggles to adapt to life with whatever resources and limitations our patients have acquired in the course of their uniquely individual lives. With good fortune, even the handicapped may escape seriously disabling illness. When such disasters occur, they can be understood only in terms of all that has shaped the premorbid personality and the operant factors in the life situation present at the time of onset of obvious breakdown. The involutional psychoses may be seen as adaptational disorders occurring when they do in a particular period of life because of premorbid personality characteristics which make them uniquely vulnerable to the special conditions of life which prevail during the age period 45 to 65.

REFERENCES

The references noted in this paper may be obtained either from the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

Medical Assistants

by BETTY EHLERT, CMA-A

ANNUAL MEETING

Ninety members from throughout Iowa attended the 20th annual meeting of the American Association of Medical Assistants, Iowa State Society, Inc., May 14, 15 and 16, 1976, at the Ramada Inn in Waterloo.

The entire convention reflected the careful planning of Judene Fischer, Black Hawk Chapter, Waterloo, and her co-chairman, Nina Kline. Program Chairman Sandy Hayungs provided an excellent program.

Members were welcomed by Black Hawk Chapter President Margaret Gardner; Neil Williams, M.D., president of the Black Hawk County Medical Society; Jon Crews, mayor of Cedar Falls; Leo Roof, mayor of Waterloo; and the Waterloo Ambassadors, representing the Waterloo Chamber of Commerce. Reverend James Bailey gave the invocation.

Nancy Winter, of Davenport, 1975-76 state president, presided at the House of Delegates. Officers elected for the coming year were:

President-Elect: Margaret Porter, CMA-AC, Cedar Rapids. Margaret has been employed for six years as medical secretary to Dr. Donald Weir, St. Lukes Methodist Hospital Rehabilitation Center. She served as Linn Chapter treasurer for two years and two years as state vice president.

Vice-President: Jean Gold, Davenport. Jean has been employed by Urological Associates P.C. for 10 years as bookkeeper and office manager. She served two years as state secretary and two years as state treasurer. She has been secretary, vice-president, president-elect and president of Scott County Chapter.

Secretary: Pauline Tappan, R.N., CMA-A, Sioux City. Pauline is office manager for McFarlane and Vaught P.C. She has served as secretary, treasurer, vice president and president of Siouxland Chapter.

Treasurer: Nina Cline, L.P.N., Waterloo. Nina is employed by Dr. Cecil Seibert of Waterloo. She is a past president of Black Hawk Chapter and has also served as vice-president.

Donald J. Ahrenholz, M.D., presented a program on "Reconstructive Surgery" and Robert Soll, M.D., spoke on "Multiple Sclerosis." A panel discussion on "Care of the Well Diabetic" included Robert Hedican, M.D., Karl Jauch, M.D., Luke Tan, M.D., Richard A. McKay, M.D., and William Gronen, D.P.M., with Mrs. Dixie Rohle, R.N., as Moderator.

Mrs. Bobbie Ecker gave a delightful floral demonstration with flair and expertise.

A highlight of the meeting was the Saturday banquet with Robert Bremner, M.D., as master of ceremonies. The installation ceremony for new officers was led by Installing Officer Charlotte Fell, CMA-A, of Des Moines. Past state presidents were honored and took part in the installation ceremony. Leanna Rist, CMA-A, Des Moines, was installed as the 1976-77 state president. Musical entertainment was furnished by Central High School, Waterloo.

Jeanne Green, CMA-A, of Davenport, national vice-president, gave an inspiring talk on "Two Decades of Dedication and Service." Mrs. Green was given special honor during the meeting, as was James F. Bishop, M.D., honorary member, for his many years of care and concern for the American Association of Medical Assistants, Iowa State Society, Inc.

A reception following the banquet honored Leanna Rist, CMA-A, president, and James F. Bishop, M.D., president, Iowa Medical Society.

The 1977 state meeting will be April 15, 16 and 17, 1977 in Mason City.

AAMA'S ANNUAL MEETING WILL BE HELD IN CHICAGO, SEPTEMBER 13-19, 1976, at the Palmer House.

(Continued on page 352)

MEDICAL ASSISTANTS

(Continued from page 351)

CERTIFICATION

The Mini Test (simulated certification test) was offered during the state meeting to give encouragement toward certification. The actual certification test was given June 4, at various test centers throughout the United States. This year, for the first time, the basic certification test will be given in the fall. The examination will continue to be offered twice each year.

Certification will continue to be a vital program. A revalidation program is under development to provide for the continued competency of the Certified Medical Assistant. The plan would provide the option to revalidate one's certification at five year intervals, by examination or by a point system, such as CEUs (continued education units).

PEDIATRIC CONFERENCE

Major topics to be considered at the Annual Postgraduate Conference in Pediatrics to be held at the University of Iowa September 9 and 10 are infectious disease and pharmacology. For more information, contact James A. Stehbens, Ph.D., Department of Pediatrics, University Hospitals, Iowa City, Iowa 52242.

Morbidity Report for June, 1976

Disease	June 1976	1976 to Date	1975 to Date	Most June Cases Reported From These Counties
Amebiasis	6	32	11	Scattered
Blastomycosis	2	2	—	Black Hawk, Johnson
Chickenpox	416	8921	6596	Dubuque, Johnson
Clonorchis sinensis infestations	1	1	—	Hancock
Conjunctivitis	83	1470	842	Black Hawk, Clinton
Enclolimax nana	1	1	—	Fayette
Erythema infectiosum	16	154		Black Hawk
Gastrointestinal virus inf.	148	16233	5495	Scattered
Giardiasis	1	16	8	Adair
Hepatitis				
A (infectious)	11	68	92	Polk
B (serum)	11	50	50	Polk
Histoplasmosis	4	8	12	Franklin, Johnson, Linn
Impetigo	14	482	325	Clark
Infectious Mononucleosis	34	662	785	Scattered
Influenza-like illness	141	42202	36119	Scattered
Meningitis, aseptic	4	10	3	Black Hawk, Linn, Pottawattamie
type unspecified due to *H. influenza*	1	3	23	Dubuque
Meningoencephalitis, viral	4	6	10	Black Hawk, Polk, Scott
Mumps	1	1	—	Black Hawk
	49	1184	982	Scattered
Pediculosis	20	269	200	Scattered
Pleurodynia	1	—	—	Dubuque
Pinworms	11	21	24	Polk
Pneumonia	24	674	687	Scott
Rabies in Animals	21	71	60	Scattered
Ringworm, body	4	165	171	Black Hawk, Clark, Linn
Roseola fever	1	1	—	Dubuque
Rubella—(German Measles)	51	90	19	Polk
Rubeola—(Measles)	18	47	461	Pottawattamie
Scabies	25	425	247	Scattered
Salmonellosis	8	56	86	Scattered
Streptococcal infections	686	10554	6844	Black Hawk, Johnson, Polk
Tuberculosis—(total ill)	4	51	65	Scattered
Tuberculosis—(bact. positive)	3	45	28	Scattered
Venereal Diseases				
Gonorrhea	567	3237	3198	Linn, Polk, Scott
Syphilis	21	163	157	Linn, Polk, Scott
Shigellosis	8	37	36	Scott

Laboratory Virus Diagnosis Without Specific Clinical Syndrome Adenovirus 1; Coxsackie B4 infection 1; Eaton's Agent infection 1; Enteropathogenic *E. coli* 1; Herpes simplex 10; Herpes zoster 1; Cytomegalovirus 5.

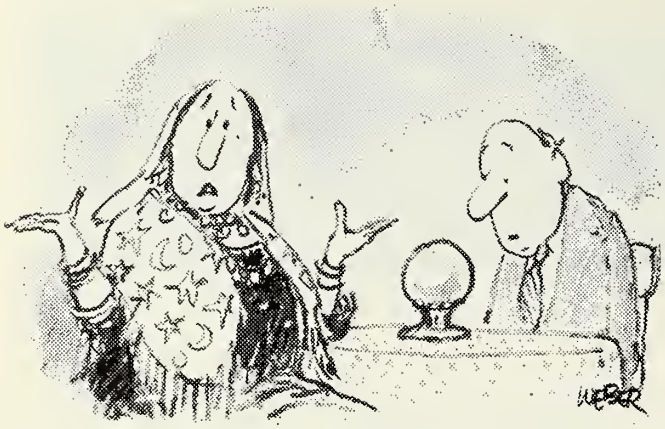
About IOWA Physicians

Dr. John Parish closed his medical practice in Grinnell July 31. Dr. Parish received the M.D. degree at Harvard Medical School and interned at Johns Hopkins Hospital in Baltimore, Maryland. He began his practice in Grinnell in 1933. . . . **Dr. Min Chung** has joined the Department of Pathology at Keokuk Area Hospitals. Dr. Chung received his medical education at Yonsei University in Seoul, Korea and completed his postgraduate work in pathology at Hershey Medical Center in Hershey, Pa., and Geisinger Medical Center in Danville, Pa. . . . **Dr. Harold C. Bastron,** Red Oak physician for 40 years, retired July 31. A graduate of U. of I. College of Medicine, Dr. Bastron began his practice in Red Oak in 1936. . . . **Dr. Charles E. Driscoll** joined the Family Care Center in Red Oak in July. Dr. Driscoll received the M.D. degree at U. of I. College of Medicine and served his internship and family practice residency at Ball Memorial Hospital in Muncie, Indiana. . . . **Dr. E. O. Theilen** and **Dr. Robert H. Richardson,** faculty members in Department of Internal Medicine at U. of I. College of Medicine, were guest speakers at a recent symposium on "Drug Administration in Acute Cardiac and Respiratory Conditions: The Nurse's Responsibility." The Iowa City event was sponsored by the American Association of Critical Care Nurses.

Dr. James Stiles has been named president of Linn County Medical Society; **Dr. Richard Sedlacek,** president-elect; **Dr. Richard Kirsch,** vice president; and **Dr. William Galbraith,** secretary-treasurer. All are Cedar Rapids physicians. . . . **Dr. Steven Morrison** has joined **Drs. C. C. Moore** and **D. W. Hurlbut** in Emmetsburg. Dr. Morrison received the M.D. degree at U. of I. College of Medicine; interned at County Hospital in San Bernardino, California; and completed family practice residency at County Hospital in Ventura, California. Prior to locating in Emmetsburg, Dr. Morrison was in private practice in Wisconsin. . . .

Dr. H. J. Fishman has closed his medical practice in Cherokee. A graduate of U. of I. College of Medicine, Dr. Fishman was in family practice in Cherokee for 23 years. . . . **Dr. Robert Railey** has joined **Drs. Peter Kepros, Dean Nierling** and **F. L. Klingle, Jr.** in family practice in Cresco. Dr. Railey received the M.D. degree at University of Kansas Medical School and completed his family practice residency in Cedar Rapids. . . . **Dr. Leland H. Prewitt,** Ottumwa physician for 44 years, retired in May. . . . **Dr. C. L. Bain,** Corning, was honored in May at reception sponsored by area residents. Dr. Bain has practiced in Corning for nearly 50 years. . . . **Dr. Saman Choontanom,** Rock Valley, has been named a fellow of American Society of Abdominal Surgeons.

Dr. Stephen R. Fromm has joined **Dr. Horst G. Blume** in the practice of neurosurgery in Sioux City. Dr. Fromm received the M.D. degree at Harvard Medical School; interned at Duke Hospital and served his residency in neurosurgery at New England Medical Center and Lahey Clinic in Boston, Mass., with academic appointment at Tufts College School of Medicine as assistant in neurosurgery and New York University Postgraduate Medical School as assistant in neurosurgery. He is certified by American Board of Neurological Surgery and is a fellow of the American College of Surgeons. . . . **Dr. Victor H. Gardner** has joined **Dr. James Shehan** in family practice in Red Oak. A graduate of U. of I. College of Medicine, Dr. Gardner practiced in Washington state for 15 years and for the past eight months has been on the emergency room staff of a Cedar Rapids' hospital. . . . **Dr. David R. Bakken,** Decorah, was recently presented a certificate by Mayo Medical School for his service to students as a preceptor in the Department of Family Medicine. . . . **Dr. Annette Fitz** has been appointed a full professor at U. of I. College of Medicine. Dr. Fitz has been on the U. of I. faculty



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since 1966. A leading authority on kidney disease, Dr. Fitz received the M.D. degree at U. of I. and interned at a hospital in Salt Lake City, Utah. . . . **Dr. Truce Ordona** has entered the private practice of psychiatry in Iowa City. Dr. Ordona is a former U. of I. faculty member.

Dr. Charles A. Waterbury, family practitioner in Waterloo for 32 years, is new director of Family Practice Residency Program in Waterloo and Cedar Falls. Following his retirement from private practice in 1974, Dr. Waterbury became associate director of UNI Student Health Center. . . . **Dr. J. S. Parmar** will assume the medical practice of **Dr. W. H. Verduyn,** Reinbeck, while Dr. Verduyn studies spinal cord injuries at Craig Hospital in Englewood, Colorado. Dr. Parmar, a native of India, has taken postgraduate training in Canada and University Hospitals in Iowa City. . . . **Dr. K. Y. Lee,** former Waukon surgeon, has opened an office in Webster City. Dr. Lee received his M.D. degree in Korea and completed his surgical residency at Veterans Administration Hospital in Des Moines. . . . **Dr. Philip R. Carapreso** and **Dr. James C. Hall** have joined the Park Clinic staff in Mason City. Dr. Carapreso received the M.D. degree at Upstate Medical School, State University of New York, and completed his residency in surgery at Polyclinic Hospital in Harrisburg, Pa. Dr. Hall received the M.D. degree at U. of I. College of Medicine and completed his residency in obstetrics and gynecology at Butterworth Hospital in Grand Rapids, Michigan. . . . At the June meeting of the Wright County Medical Society, **Dr. Glen Sizemore,** assistant professor of medicine at Mayo Medical School in Rochester, Minnesota, presented a program on diseases of the parathyroid gland.

Dr. J. E. Whitmire, Sumner, was honored recently by Sumner Rotary Club for his 45 years of medical service to the community and long tenure in Sumner Rotary Club. Dr. Whitmire is the last living charter member of the local club which was organized in 1937. . . . **Dr. M. E. Chandler** has joined **Drs. G. F. Brown** and **J. L. Bailey** in Anamosa. Dr. Chandler received the M.D. degree at U. of I. College of Medicine; interned at Broadlawns Hospital in Des Moines and completed an anesthesiology residency at University Hospitals in Iowa City. . . . **Dr. Laverne Wintermeyer,** director of pediatric education at Raymond Blank Children's Hospital in Des Moines since 1968, has been named director of the State Health Department's division of infectious diseases. . . . **Dr. John T. Kelley** has joined the Gilfillan Clinic in Bloomfield. Dr. Kelley received the M.D. degree at U. of I. College of Medicine; interned at St. Paul-Ramsey Hospital in St. Paul, Minnesota; and completed residency in internal medicine at University Hospitals in Iowa Cty.

At recent meeting of Iowa Heart Association, **Dr. Dale A. Harding,** Eagle Grove, was presented the 1976 Iowa Heart Association Staff Award for his outstanding volunteer work; **Dr. H. A. Van Hofwegen,** Spencer, was given Special Program Award for his efforts in Association's Advanced and Basic Life Support Program; and **Dr. Dorothy Ehmke,** assistant professor in Department of Pediatrics at U. of I. College of Medicine, was cited for her participation in Association's Heart Sound Screening and Hypertension Screening Programs.

DEATHS

Dr. John W. Saar, 61, former Keokuk physician, died May 12 at his home in Chino, California. Dr. Saar received the M.D. degree at U. of I. College of Medicine and interned at Salt Lake County General Hospital in Salt Lake City, Utah. He practiced medicine in Keokuk from 1947 until 1975.

Dr. Ernest G. Kieck, 81, former Cedar Rapids physician, died June 1 in Hendersonville, North Carolina, following an auto accident. A graduate of Creighton University Medical School, Dr. Kieck practiced medicine in Shellsburg and Cedar Rapids prior to his retirement in 1954. He was a past president of the Linn County Medical Society.

Dr. Charles T. Maxwell, 87, Sioux City, died June 14 at a Sioux City hospital. Dr. Maxwell received the M.D. degree at University of Chicago and interned at Cook County General Hospital. He established his medical practice in Sioux City in 1914. Dr. Maxwell was a fellow of American College of Surgeons; past president of medical staff at St. Joseph Mercy Hospital; and past president of Woodbury County Medical Society.

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OB-GYN, Board Eligible, step into fully equipped, well established practice. 3 Gyn men relocated in another city, opportunity to join 8 remaining physicians. Paid malpractice insurance and other fringe benefits. Midwest city, pop. 15,000 draw to 30,000. High employment rate, industry—agriculture diversified. Partnership 2 years. Univ. Med. Center 90 minutes away. Convenient to St. Louis, Chicago by air and rail. Bountiful hunting and fishing in Mississippi boating and recreation areas. Contact W. R. Woody, Business Manager, Valley Clinic, 20th and Avenue E., Fort Madison, Iowa. Phone 319/372-7270.

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WELL ESTABLISHED MEDICAL AND SURGICAL GROUP desires to expand the Family Practice Department from four to six family practitioners. Salary first year—partnership second. No buy-in required. Check this one—it's an excellent opportunity in a good stable economic location with plenty of social, cultural and recreational activities. Contact either G. W. Glenn, Business Manager, or Robert A. Weyhrauch, M.D., 1125 West Fourth Street, Waterloo, Iowa 50702. Phone 319/234-1541.

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WANTED—FAMILY PRACTITIONER to join 8-man multispecialty group. Excellent clinic and hospital facilities. Unusually progressive small community in which to live and raise a family. Excellent salary and benefits, partnership in twelve months, liberal vacation and meeting time. Contact Richard A. Callis, Administrator, McCrary-Rost Clinic, Lake City, Iowa 51449. Telephone 712/464-3194.

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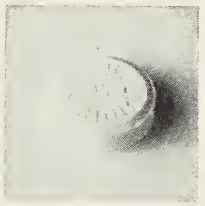
respond to one

According to her major
aptoms, she is a psychoneu-
ic patient with severe
ciety. But according to the
cription she gives of her
lings, part of the problem
y sound like depression.
is is because her problem,
nough primarily one of ex-
sive anxiety, is often accom-
nied by depressive symptom-
logy. Valium (diazepam)
provide relief for both—as
excessive anxiety is re-
ed, the depressive symp-
ns associated with it are also
en relieved.

There are other advan-
es in using Valium for the
nagement of psychoneu-
ic anxiety with secondary
pressive symptoms: the
chotherapeutic effect of
lium is pronounced and
id. This means that im-
vement is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



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in psychoneurotic
anxiety states
with associated
depressive symptoms

veillance because of their predisposi-
to habituation and dependence. In
gnancy, lactation or women of child-
ring age, weigh potential benefit
inst possible hazard.

cautions: If combined with other psy-
tropics or anticonvulsants, consider
efully pharmacology of agents em-
ed; drugs such as phenothiazines,
cotics, barbiturates, MAO inhibitors
other antidepressants may potentiate
action. Usual precautions indicated in
ents severely depressed, or with latent
ression, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

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President's Page

Over the past 9 or 10 months representatives of the IMS Legislative and Medico-Legal Committees have appeared several times before the Legislative Interim Study Committee on Medical Malpractice. This preceded long and hard efforts "on the hill" during the 1976 session of the General Assembly to obtain some additional constructive and meaningful medical liability legislation.

Despite strong bipartisan support in the House, the Senate effectively emasculated the proposed bill and it was allowed to expire peacefully. One senator opined they could not pass legislation favoring one group. The Senate did, however, approve an amendment obligating health professionals, under threat of punishment, to report any instances of malpractice observed among their colleagues. Since the same obligation was not imposed upon lawyers, architects, engineers, beauty operators and other licensed professionals, it would seem that legislation can be aimed against a specific group. This amendment was part of the Senate-passed bill which died from lack of consideration by the House.

One of our problems is the apathy of Iowa physicians in the realm of legislator communication. Lawmakers cannot know all things about all subjects. Therefore, they welcome information and opinion from those they represent. Unless opinion is forthcoming in significant amount on one side of a question, the legislator can conclude reasonably that only the opposing view, vigorously and volubly supported, is the important one. This is part of what happened to us. At one of my own county society meetings last spring I inquired how many had ever written one of their legislators to express an opinion on any subject. In a roomful of people, about six hands went up. Even the devotion of the IMS committees cannot overcome that kind of inertia.

Your legislators are at home now, many preparing to campaign for re-election. They are, then, particularly attuned to opinions expressed by the voters. Seek them out, tell them what you think, and support those of either party who will support us. The liability insurance problem is still with us, troublesome as ever, and legislation will be proposed again at the next session.

James F. Bishop, M.D.

James F. Bishop, M.D., President

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State Department of Health

The *Recommendation of the Public Health Service Advisory Committee on Immunization Practice on Influenza Vaccine—Supplemental Statement* follows this introductory comment. The Preliminary Statement was published in the July issue.

A/New Jersey influenza vaccine is expected to arrive in Iowa late this month. A delay resulted from liability deliberations at the federal level. Legislation was approved August 11 which assigned certain liability obligations to the federal government and cleared the way for delivery of the vaccine.

Federal public health officials have advised vaccine will be available 30 days after the liability issue is resolved. Due to the delay, local immunization plans will have to remain flexible to accommodate vaccine delivery when it occurs.

When the vaccine is received it will be shipped to all participating hospital pharmacies in the state. The hospital pharmacy will then be used as a vaccine distributing point in the community.

An "informed consent" statement has been prepared by the federal government and is now being printed by the state. The purpose of the statement is to inform each recipient of the benefits and risks involved in taking influenza vaccine. The statement will be available to physicians for use in their practices but its use is not mandatory.

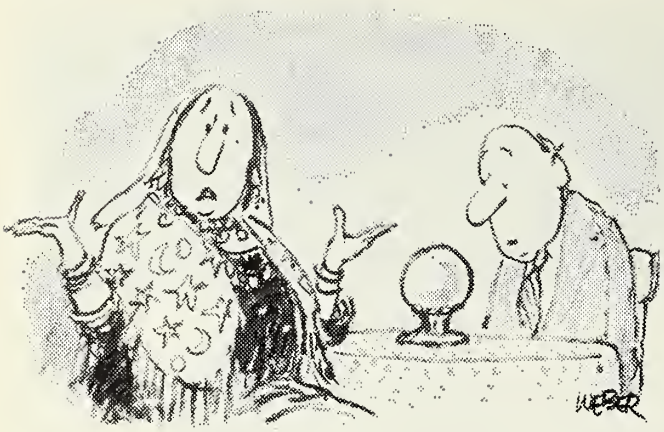
Vaccine trials have been partially completed. The U. S. Advisory Committee on Immunization Practice recommends a 200 CCA unit dose for all individuals 18 and older. There is a possibility that those persons between 18 and 24 will need a booster dose. The vaccine trials were inconclusive for those under 18. Recommendations for this latter group should be available September 15, 1976. This vaccine has proven to be very effective (85-90%) with minimal side effects (2%). Side effects are tenderness and redness at site of injection, malaise, and fever (less than 101 degrees).

INFLUENZA VACCINE— SUPPLEMENTAL STATEMENT*

This Committee's preliminary statement on influenza for 1976-77 was published in early June.* In it there was extensive reference to field trials of prototype vaccines to be used in the National Influenza Immunization Program. The trials were conducted to provide a basis for making specific recommendations on vaccine formulation and vaccine dosage for different age groups and for accurately describing the side effects that might be expected to follow vaccination.

Data from these field trials were analyzed at an Influenza Workshop held in Bethesda, Maryland, on June 21, 1976. The Workshop was sponsored by the National Institute of Allergy and Infectious Diseases (National Institutes of Health), the Bureau of Biologics (Food and Drug Administration), the Center for Disease Control, all in the Department of Health, Education, and Welfare, and by the Department of Defense—the same agencies that had sponsored the vaccine studies. The following summary of results, of

* Supplemental to Influenza Vaccine—Preliminary Statement, published in the MMWR (25)21:165-171, June 4, 1976.



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partial recommendations on swine influenza vaccination for adults, and of related comments and recommendations has been derived from review of field trial data and consideration of other important issues.

SWINE INFLUENZA VACCINE FIELD TRIALS (SPRING 1976)

Field trials of prototype vaccines from the 4 United States influenza vaccine producers involved more than 5,200 adults and children. The trials were designed to evaluate the immunogenicity and reactogenicity of different doses of swine influenza vaccines. Trials were double-blind with placebo controls and used comparable protocols and analytical methods. All serum samples were tested at CDC.

Vaccines in the field trials were monovalent preparations of swine influenza virus (Hsw1N1), bivalent preparations including both swine influenza virus and A/Victoria/75 (H3N2), and monovalent B preparations containing B/Hong Kong/72. All manufacturers used standard procedures to purify, concentrate, and inactivate the virus. Two manufacturers supplied whole-virus vaccines, and 2 provided split-virus (chemically disrupted) vaccines.

Preliminary analysis of field trial data provides the following general conclusions:

1. Approximately 90% of the vaccinees 25 years of age or older responded well to even the lowest adult dose (200 CCA units) of monovalent swine influenza vaccines; whole-virus and split-virus vaccines induced comparable antibody responses. Vaccine side effects, principally low-grade fever, malaise, and myalgia, among the adult volunteers were most frequent with the highest test dose (800 CCA units) of whole-virus vaccines. Only about 2% of adults receiving 200 CCA unit vaccines had any such effects, a rate essentially equivalent to that following injection of placebo material.

2. Children 3-10 years old had less favorable immune responses to the swine influenza vaccines than did adults. Although whole-virus vaccines were considerably more effective inducers of antibody in this age group than were split-virus vaccines, the whole-virus antigens were also more reactogenic, even at the lowest childhood doses used (50 and 100 CCA units). Additional field trials with children and adolescents will be needed to measure the immunogenicity and reactogenicity of other doses of vaccine and the benefit of second doses.

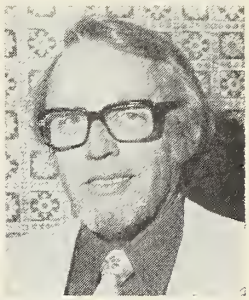
3. Young adults ages 18-24 had less favorable antibody responses to the swine influenza vaccines than did older adults. Like younger children, their best responses were to whole-virus vaccines, particularly to the most potent ones tested (800 CCA units). However, persons in this age group experienced considerably fewer side effects to the more potent vaccines than did young children.

4. Bivalent A vaccines containing both swine influenza virus and A/Victoria/75 virus, either whole or split, at 200 CCA or 400 CCA units of each component antigen, were about equally immunogenic in persons 25 years of age or older. They were less effective in younger persons. Side effects from these vaccines were similar in adults to those from monovalent swine influenza vaccines.

5. Monovalent B/Hong Kong/72 vaccines con-

(Please turn to page 370)

The Question Box



By THOMAS E. KIERNAN, M.D.

THE POLITICAL SCENE

Dr. Kiernan is chairman of the Iowa Medical Political Action Committee and is a radiologist in Newton. He reviews the election year opportunities which are available to Iowa physicians and urges participation.

As the important November elections approach, what advice do you have for Iowa physicians as to their personal involvement in the support of candidates?

Personal involvement is of paramount importance. This can be accomplished through support of candidate campaign committees and through personal contributions of time and money.

What about IMPAC support?

Equally important are IMPAC and AMPAC contributions. Over and above personal contributions to candidates, your money is best spent with IMPAC. As an individual, you are limited to a total of $1,000 in any personal contribution. Through IMPAC, your profession can contribute up to $5,000 and can ask AMPAC to consider that same contribution and add an additional $5,000 to the candidate's support. Through this mechanism (the PAC's) your individual $100 contribution is increased a hundredfold. I would consider that a pretty good deal. This contribution is presented to the candidate personally and he is then aware that PAC is interested and is working in his behalf. There is one important qualification—IMPAC must first have the initial funds before it can undertake any matching effort.

The problem of voter apathy has been cited as a major concern in 1976. How can the physician help avert this?

We in medicine cannot afford to be apathetic. The legislative programs we support will be successful only if we are able to help elect lawmakers who are willing to hear our explanations and act responsively. We can be effective only through personal contacts with legislators—by making ourselves known in this election year to the 125 persons who will be elected or reelected to the Iowa General Assembly. This we can do by candidate support and the effort will be of as much or even more importance than the presidential race.

What are the activities in which IMPAC is engaged at this point in the campaign?

Your IMPAC board is active in the congressional races and is working hard on contacts with candidates for state legislative seats. We are short of funds. Our membership is better now than it has been the past three years but we need more members and we need more help from our present members both in dollars and in advice as to what candidates need and deserve support. IMPAC needs your participation now.

INFLUENZA VACCINE

(Continued from page 368)

taining 500 CCA units of antigen produced good antibody responses in nearly all adult vaccinees tested. The antigen induced few side effects of its own, and, when given simultaneously with bivalent A vaccine, did not appear appreciably to enhance reactogenicity.

6. Vaccines administered by needle/syringe and by jet injector produced comparable rates of seroconversion and levels of antibody response.

INFLUENZA VACCINE RECOMMENDATIONS

General Comments

Results of the recent field trials provide clear evidence that adults of approximately 25 years of age or older can safely and effectively be immunized against A/New Jersey influenza with a single dose of vaccine. Furthermore, the trials indicate that younger adults and children as young as 3 years old can also be safely immunized but that additional data will be needed before specifying the precise vaccine potency and optimal schedule for them. Although data from additional field studies will be needed to substantiate and complete recommendations for the young adult and childhood age groups, plans for vaccinating all age groups of the population should continue.

Studies underway now and others soon to begin should be completed by mid-to-late-September in time for vaccination programs to proceed.

The current recommendations address the population above secondary school age, namely that 18 years of age and older. Although within this adult group, those 18-24 years old are immunologically distinctive from those 25 years of age and older, as a result of having had less experience with various naturally occurring influenza viruses, all persons in this age group can be given the same potency vaccine. If additional vaccine trials in the 18- to 24-year-old group indicate that sufficient benefit will be derived from a second dose of vaccine, it will be recommended. Furthermore, since whole-virus vaccine produces better antibody responses in the 18- to 24-year-old group, plans should be made to utilize this vaccine for this group.

Swine Influenza Vaccine Formulations

For those 18 years of age and older, influenza vaccines, both monovalent A and bivalent A, will contain 200 CCA units of A/New Jersey/76 (swine influenza virus). The bivalent A vaccine will also contain 200 CCA units of the A/Victoria/75 antigen. A single dose of either vaccine should result in antibody responses against swine influenza generally considered protective in at least 85-90% of vaccinees of approximately age 25 or more. Persons 18-24 years of age will probably not respond as well to the swine influenza antigen, but at least 85% of those receiving whole-virus vaccine should develop demonstrable antibodies.

Side effects from these vaccines, including 1-2 days of low grade fever, malaise, and myalgia, should occur in less than 2-3% of vaccinees 18 years of age or older.

High-Risk Persons 18 Years of Age and Older

Bivalent A Vaccine: *One* dose of *bivalent A* influenza vaccine containing 200 CCA units of A/New Jersey/76 (swine influenza virus) and 200 CCA units of A/Victoria/75 should be given. (As noted, if additional field trials show sufficient benefit from a second dose for persons 18-24 years old, it will be recommended.)

Monovalent B Vaccine: *One* dose of *monovalent B* influenza vaccine containing 500 CCA units of B/Hong Kong/72 should be given. This vaccine will be available only through commercial sources. It can be given at the same time as the bivalent A vaccine or at another time. If given concurrently, slightly enhanced side effects might be observed. In vaccinating an adult who has previously experienced significant side effects from influenza vaccines, it would be prudent to give the 2 vaccines separately, preferably with the bivalent A vaccine's being given a few days or a week or more before the monovalent B vaccine.

General Population 18 Years of Age or Older

Monovalent A Vaccine: *One* dose of *monovalent A* influenza vaccine containing 200 CCA units of A/New Jersey/76 (swine influenza virus) should be given. (As noted, if additional field trials show sufficient benefit from a second dose for persons 18-24 years old, it will be recommended.)

General Population 17 Years of Age or Younger

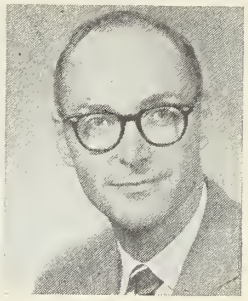
Monovalent A Vaccine: Recommendations will be made based on results of studies now underway.

Precautions

Before being vaccinated, persons known to be hypersensitive to egg protein should be given a skin test or other allergy-evaluating test using the swine influenza vaccine as the antigen. Persons

(Please turn to page 377)

Educationally Speaking



by RICHARD M. CAPLAN, M.D.

PEOPLE WHO NEVER QUESTION

In the zany but penetrating wisdom that characterizes Joseph Heller's *Catch-22*, a colonel was disturbed at the disruption of an educational session by individuals who asked questions. He therefore forbade questions except from those persons who never asked any. "Soon the only people attending were those who never asked questions, and the sessions were discontinued altogether, since . . . it was neither possible nor necessary to educate people who never questioned anything."

"To question" means both "to doubt" and "to ask." Doubting may be verbalized or not; asking is usually made explicit. In either case *thinking* must be taking place. It is that process of thinking which permits and generates what we call education. Continuing education, then, requires continued thinking, doubting and asking. Complacency about what we know and do is the enemy of continuing education.

Is there such a thing as a stupid question? A question may be born of ignorance, and may be the antidote to ignorance. A question may be careless, that is, arising from inattention to what is apparent or has just been answered. Questions may be asked about unimportant matters, or about profundities. In science and many branches of philosophy or religion we praise the individual who asks the most penetrating or insightful questions, because what we term progress flows from the answers to questions. No questions mean no answers. But a stupid question? . . . probably not.

The frequency of questioning is related to the rate of change in a reciprocating fashion. More questioning produces more change; times of rapid change stimulate more questioning, both asking and doubting. The person who asks often is generally receptive to change.

Our common greetings, "Whaddya know?" and "What's new?" are generally asked only as rhetorical questions. The person whose voice or behavior frequently says, "What's new?" and really seeks an answer, is a person engaged in his continuing education. In an epoch of medical progress such a physician will provide better care for his patients, and merits our praise.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

MEDICAL MISCELLANY

MEDICAID UNCERTAINTY . . . Proposed Title XIX curtailments have been revealed by Social Services Commissioner Kevin Burns. Burns has said cutbacks are necessary if Iowa is to stay within the $50 million allocation of the General Assembly. Imposition of a 10-day limit on hospitalization in September is one of the limitations cited as necessary. Further deliberations over these matters were scheduled August 23 and 25.

HOSPITAL LIABILITY . . . The Iowa Hospital Association is creating an insurance corporation for purposes of providing liability coverage to participating hospitals. It is to be known as the Iowa Hospital Mutual Insurance Corporation and will be fully owned and operated by Iowa hospitals. The State Insurance Commissioner has been kept apprised of the project and hope is the IHMIC will be able to write coverage by October 1.

too many tenants?

If rental units are included in your investment program, it could become a problem of just a handful of tenants being too many if they use up your precious patient-time with complaints and demands. As a busy professional person you cannot afford to spend your all-too-short days pampering your investments, whether they be rental property or stocks or bonds or other real estate, at the expense of your practice. And your investment program is too important to let suffer for lack of attention. The happy solution is to turn your financial problems over to an Iowa bank Trust Department. They have management programs especially tailored for professional people. So whether you have too many tenants or not enough, or if your investments are in other areas, an Iowa Trust Department can save you time and money.

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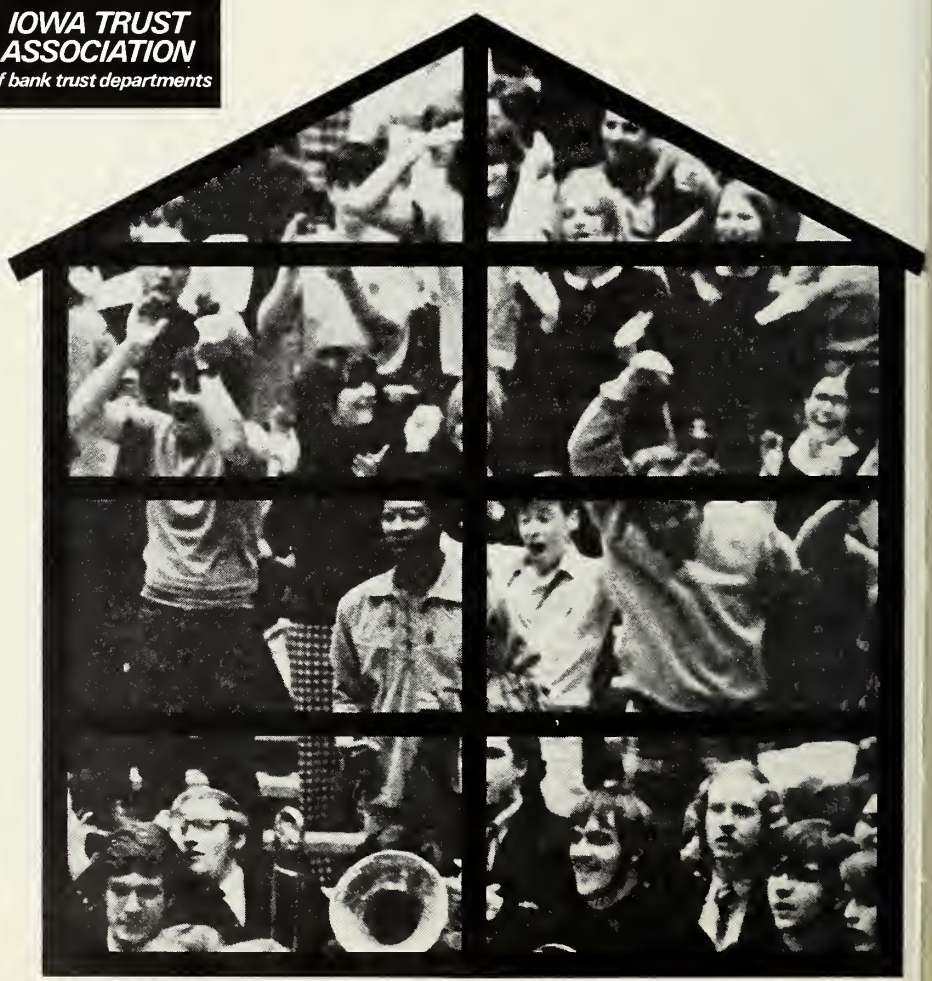

SCIENTIFIC ARTICLES

Use of Prophylactic Antibiotic And Vaginal Cuff Inflammation

ROBERT E. HEDICAN, JR., M.D., and
GLORIA E. SARTO, M.D.
Waterloo

Use of a short term prophylactic antibiotic in specific response to cuff inflammation in vaginal surgery is discussed. A prospective double blind study is evaluated. Of 70 patients, 38 received the drug and 32 received the placebo. Morbidity was 7.9% in the drug group and 28.1% in the placebo group.

THE MORBIDITY following vaginal surgery is noted to vary from 26.7% to 45%.[1, 2] Post-operative morbidity is generally accepted as being higher when vaginal hysterectomy is accompanied by plastic repair.[1] The complications include urinary tract infection, pelvic infections, respiratory infections and occasionally drug reactions and fevers of unknown origin. Vaginal cuff inflammation with pelvic peritonitis is one of the most serious complications.

Previous investigators have reviewed the use of prophylactic antibiotics in vaginal surgery.[1, 3, 4] In this prospective double blind study only vaginal cuff inflammation was considered when evaluating the short term administration of cephaloridine.

MATERIALS AND METHODS

All patients admitted to the gynecology service from March 3, 1971 to April 26, 1972 were included in the study if: 1) they were to have elective vaginal surgery, 2) had no evidence of preoperative infection, 3) were not on antibiotic therapy, 4) had no allergy to penicillin nor elevation of BUN, 5) and gave informed consent.

Morbidity was defined as:

1) Temperature of at least 100.4 on two occasions 6 hours apart exclusive of the day of surgery.

2) Subjective pelvic pain.

3) Lower abdominal pain and rebound tenderness on examination.

4) No other source of infection evident.

In addition, tender rectal mass and vaginal discharge were considered as further evidence of cuff inflammation.

All patients included in the study had complete history and physical examination. White cell count, differential, hematocrit, BUN, and urinalysis were performed preoperatively; vagi-

Dr. Hedican is in the private practice of obstetrics and gynecology in Waterloo. Dr. Sarto is now affiliated with Prentice Women's Hospital and Maternity Center of Northwestern Memorial Hospital in Chicago, Illinois. The study reported was undertaken at the University of Wisconsin during the residency training of Dr. Hedican.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF SEPTEMBER, 1976.

TABLE I

TYPE OF OPERATION

	Vaginal Hysterectomy Without Plastic Procedure		Vaginal Hysterectomy and Plastic Procedure	
	Drug	Placebo	Drug	Placebo
Total	3	4	35	28
Number morbid	0	2	3	7
% Morbid	0	50%	8.6%	25%

nal cultures, BUN, and when appropriate, urine cultures were obtained postoperatively.

All patients had a vaginal prep of 8 minutes with Povidone-Iodine (Betadine) soap and 2 minutes with Povidone-Iodine (Betadine) solution. All vaginal cuffs were closed and only 2 patients (one in each group) had vaginal packs.

The patients were numbered consecutively 1-70 and were randomly assigned either the placebo or drug by the pharmacy. Following completion of the study and identification of patients with vaginal cuff inflammation, the code was broken.

The study drug was administered in a fashion similar to that of a previous investigator: [5]

1) 1 gm intravenously at the beginning of the operation.

2) 1 gm 1.M. at 5 hours postoperatively.

3) 1 gm 1.M. at 12 hours postoperatively.

Fisher's exact test (one-tailed) was used to evaluate the hypothesis of equal incidence.

RESULTS

The results are summarized in Table I. In the drug group, 3 patients out of 38 (7.9%) had vaginal cuff inflammations, as compared to 9 patients out of 32 (28.1%) in the placebo group. The series is further divided into vaginal hysterectomies with and without repair. Fisher's exact test (one-tailed) indicates the probability of such an extreme outcome in favor of the drug would be unlikely ($p < 0.05$) if it were ineffective.

Table II lists the age, type of procedure, operating time, blood loss and additional pertinent information in those patients who received the drug. For comparison, the patients in the placebo group are listed in Table III.

COMMENT

It has been stated that organisms isolated from the vagina are identical to those found in the gastrointestinal tract.[4, 6] A significant reduction in the frequency of wound and intraabdominal sepsis was reported in an excellent prospective double blind study utilizing cephaloridine prophy-

(Please turn to page 378)

TABLE II

DRUG GROUP

Pt. No.	Age	Procedure	Length of Procedure	Blood Loss	Misc.
3	33	Vag. hyst. AP repair	105 min	600 cc	Insulin dependent diabetic
36	28	Vag. hyst. AP repair	160 min	1500 cc	Diabetes mellitus adult onset
39	42	Vag. hyst. (morcellation) AP repair	135 min	1600 cc	

TABLE III

PLACEBO GROUP

Pt. No.	Age	Procedure	Length of Procedure	Blood Loss	Misc.
2	26	Vag. hyst.	65 min	400 cc	8 weeks post-partum
8	28	Vag. hyst. AP repair	100 min	500 cc	8 weeks pregnant
11	33	Vag. hyst. AP repair	105 min	600 cc	Vaginal pack
19	40	Vag. hyst. AP repair	90 min	600 cc	
29	29	Vag. hyst.	55 min	300 cc	Infected cuff hematoma
30	31	Vag. hyst. AP repair	130 min	1500 cc	
31	31	Vag. hyst. AP + enterocele repair	140 min	1200 cc	
44	31	Vag. hyst. AP repair	110 min	1100 cc	
55	55	Vag. hyst. colpocliesis	175 min	2000 cc	

Another Look at Pediatric Urologic Evaluation

RICHARD L. VAUGHT, M.D.
Sioux City

Normal urinalysis and a normal intravenous urogram do not necessarily rule out significant urologic problems. The author cites four cases to illustrate his contention.

In 1968, J. A. Askin wrote, "The years 1940 to 1945 mark the era when pediatricians were first becoming aware of the fact that a congenital anomaly of the excretory system may exist without the presence of white or red cells in the urine."[1] So, for the past 30 years it has been generally recognized that a normal urine analysis does not rule out significant urologic disease in a child. However, in a recent monograph on pediatric medicine F. G. Smith, Jr., noted that "If the intravenous pyelogram is normal, no further evaluation is necessary unless there is a recurrence (of the infection) or the bacteriuria persists."[2] So the idea that a normal urine analysis and a normal x-ray indicates a normal urinary tract is still accepted. This philosophy has resisted change like the rock of Gibraltar.

Over the past 10 years there have been many articles which tend to confirm the idea of silent renal damage[3–8] as well as altered renal growth rates[9, 10] associated with persistent reflux (either infected or "sterile" reflux). In addition to such articles as these, there have been various estimates that the patient may have 25% to 40% loss of renal function by the time there is evidence of significant damage noted in the intravenous pyelogram (IVP).

In view of these findings, it seems important for the problems associated with reflux and obstruction to be taken into consideration when deciding upon the extent of evaluation warranted for a child with urologic problems.

The author is in the private practice of pediatric urology in Sioux City, Iowa.

H. M. Radwin wrote, "It must be recognized that the common practice of managing urinary tract infection in children by administering chemotherapeutic agents until symptoms, fever and bacilluria disappear has not been of value in preventing progressive deterioration of the kidneys and recurrent infection. . . . The reason for dwelling on this dismal record is to express the realization that many of our concepts must be re-examined, and our premises re-evaluated."[11]

I would like to pursue this idea one step further by presenting four cases briefly. The urine analyses and urographic reports are those of the hospital laboratory and radiologist.

CASE ONE

C.K. was a 7-year-old boy toilet trained by age 2. He was dry for approximately one year. He had a recurrence of nocturnal enuresis at age 3. This continued as an "every night" occurrence, associated with some urinary urgency. When seen in the office he had had two recent episodes of daytime wetting and increasing frequency of urination.

The urine analysis was normal, and the I.V.P. was reported as normal, but on further evaluation he was found to have bilateral total vesicoureteral reflux with blunting of the calyces and extravasation of contrast material into the parenchyma of the upper pole of the right kidney (Figure 1).

CASE TWO

L.K. was a 2½-year-old girl recently toilet trained and dry during the day for approximately 2 months. She then had a recurrence of diurnal enuresis and was found to have a urinary tract infection. The infection was treated by her pediatrician and cleared promptly, but the daytime wetting persisted. When referred for further evaluation, the urine analysis and the I.V.P. were both reported as normal. The cystourethrogram,

Figure 1. (C.K.) Cystogram showing bilateral total reflux with calyceal blunting and extravasation into the right upper pole.

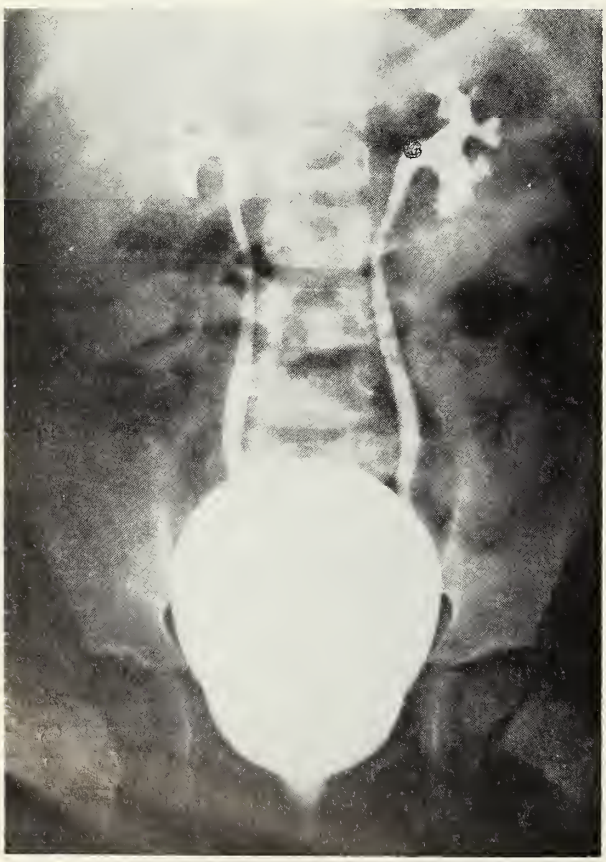

Figure 2. (L.K.) Cystogram showing bilateral total reflux with blunting of the calyces.

Figure 3. (M.H.) Cystogram showing bilateral total reflux despite a "normal" I.V.P.

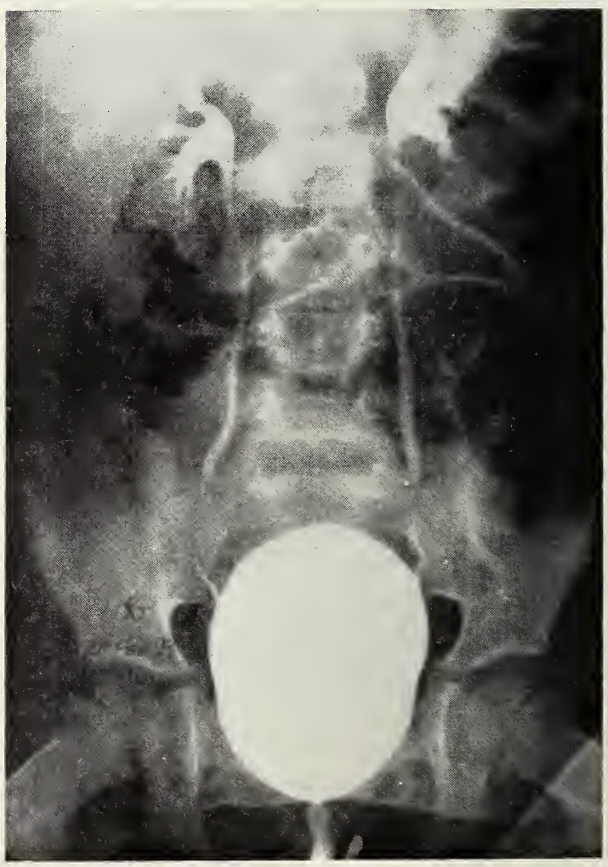

Figure 4. (J.B.) Again the cystogram shows bilateral total reflux with calyceal blunting at voiding pressure.

however, showed bilateral, total reflux with calyceal blunting (Figure 2).

CASE THREE

M.H. was a 6½-year-old boy seen because of nocturnal and diurnal enuresis "all his life." The urine analysis and I.V.P. were reported to be normal. The voiding cystourethrogram again showed bilateral total reflux with calyceal blunting (Figure 3).

CASE FOUR

J.B. was a 4-year-old boy seen because of an abnormal voiding pattern. His mother indicated the boy started his urination with a dribble, interrupted the stream, and then dribbled some more; then in a short time he was wet again. The urine analysis was reported as normal, as was the I.V.P., but the cystourethrogram showed bilateral total reflux with calyceal blunting (Figure 4).

SUMMARY

These four cases illustrate the idea being stressed. Although many children with serious urologic problems do have persistent infection or abnormal urograms, a *normal* urine analysis and a *normal* intravenous urogram *do not* necessarily rule out significant urologic problems. If the child has recurrent or persistent *symptoms*,[12] a complete urologic evaluation should be obtained.

REFERENCES

The references noted with this article may be obtained either from the author or from THE JOURNAL OF THE IOWA MEDICAL SOCIETY.

INFLUENZA VACCINE

(Continued from page 370)

with adverse reactions to such testing should not be vaccinated.

Persons with acute febrile illnesses should not be vaccinated until they have recovered.

SIDE EFFECTS AND REACTIONS, GENERAL ASPECTS

Side effects of influenza vaccine are generally inconsequential and occur at low frequency. Severe reactions are uncommon, and truly disabling effects appear to be exceedingly rare. Three types of responses have been described.

1. Fever, malaise, myalgia, and other systemic symptoms of toxicity occurring 6-12 hours after vaccination and persisting 1-2 days. These responses to influenza vaccine are usually attributed to characteristics of the influenza virus itself (even though it is inactivated in available vaccines) and represent the bulk of the side effects of influenza vaccination. Such effects occur most frequently in children and in others who have had no previous experience with influenza viruses comparable to the vaccine antigen(s).

2. Immediate, presumably allergic, responses, such as flare and wheal or various respiratory expressions of hypersensitivity. These reactions are exceedingly uncommon but can occur after influenza vaccination. They probably derive from exquisite sensitivity to some vaccine component, most likely to residual egg protein. Although current influenza vaccines contain only a minute quantity of egg protein, they do, on rare occasions, provoke hypersensitivity reactions.

3. Neurologic disorders, including such central nervous system conditions as encephalopathy, with at least temporal association with influenza vaccination. A survey of the medical literature since the early 1950s revealed only about a dozen such reports. Almost all persons affected were adults, and the described clinical reactions began as soon as a few hours and as late as 2 weeks after vaccination. Full recovery was almost always reported. Three fatalities have been reported in temporal association with influenza vaccination. However, in 2 instances, the patients displayed clinical characteristics and had antecedents which strongly suggested causes other than influenza vaccine, and the third was equally compatible with another viral disease.

In summary, influenza vaccine has only rarely, if ever, been associated with severe adverse reactions or permanent disability. Although vaccination relatively frequently causes transient redness and tenderness at the injection site and sometimes causes such systemic reactions as low-grade fever, malaise, and myalgia for 1-2 days, influenza vaccine is considered to be very safe and is suitable for widescale, community use.

PREGNANCY

Elevated rates of maternal and fetal mortality and of congenital anomalies and other fetal effects resulting from influenza infection during pregnancy have been widely discussed. Numerous re-

Source: MMWR Vol. 25, No. 28, July 23, 1976.

INFLUENZA VACCINE

(Continued from preceding page)

ports during the 1918-19 influenza pandemic and a limited number of small but better controlled studies in 1957-58, when the Asian influenza pandemic occurred, suggest that influenza can result in increased maternal deaths and fetal wastage. However, a number of prospective studies in the past decade or more have failed to corroborate this association. Although there are no persuasive data to document that pregnancy is a risk-factor with influenza, the effect of swine influenza in pregnancy cannot be forecast with assurance.

Physicians generally avoid prescribing unnecessary drugs and biologics for pregnant women, especially in the first trimester; however, there are no data specifically to contraindicate vaccination with the available killed virus vaccine in pregnancy. Women who are pregnant should be considered as having essentially the same balance of benefits and risks regarding influenza vaccination and influenza as the general population.

VAGINAL CUFF INFLAMMATION

(Continued from page 374)

lactically in elective operations upon the gastrointestinal tract.[5]

If both of the previous statements are true it was questioned if the incidence of vaginal cuff inflammation could be significantly reduced by the administration of cephaloridine following a similar protocol. The results of this study appear to confirm this contention.

ACKNOWLEDGMENTS

This investigation was supported by the Lilly Company, who also supplied the cephaloridine (loridine) and placebo. It was conducted within the Department of Gynecology and Obstetrics, University of Wisconsin Medical School.

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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

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Histographic Surgery For Cutaneous Malignancy

WILLIAM C. FRITSCH, M.D., and
ROGER I. CEILLEY, M.D.
Iowa City

The merits of treating certain skin cancers by histographic surgery are set forth. Note is made of statistics which show a five-year cure rate in excess of 90 per cent.

Skin cancer is the most common malignancy seen in man. In Iowa it is estimated there are more than 4,000 new cases each year.[1] The majority of these tumors can be satisfactorily treated with surgical excision, curettage and electrodesiccation or irradiation. There are, however, a significant number of these lesions which can be treated better by the histographic method. Other terms which describe this type of surgery include Mohs surgery, chemosurgery, and microscopically monitored surgery; fresh or fixed tissue technique. Tumors best treated by the histographic method include tumors in difficult locations (eyelids, medial canthi, pinnae, nasolabial folds, nasal alae, penis and digits), tumors with vague clinical margins, tumors that are clinically or histologically morpheaform or fibrotic, and tumors that are recurrent or large.

This paper details the experience with histographic surgery at the University of Iowa for one year beginning February 1975. The method, which was pioneered by Dr. Frederic Mohs,[2] provides immediate visual evidence of the adequacy of excision and provides an excellent cure rate. The reliability of this technique is well established. Dr. Mohs recently reported[3] a consecutive series of over 7,000 basal cell carcinomas and over 2,500 squamous cell carcinomas of the skin. He achieved a five-year cure rate of 99.3% and 94.4%, respectively. In these series 20% had recurred after previous treatment with some form of surgery or radiation and a considerable number were advanced cancers. The procedure consists of microscopically monitored excision of fresh tissue or tissue that has been chemically fixed in situ with zinc chloride paste. The specimen is divided into small blocks that will fit on a glass slide and then frozen sections are removed from the undersurface horizontally (parallel to the surface). By marking the edges of the block with different colors and using a system of mapping, the tumor is excised until there is a microscopically proven tumor-free plane. Areas of tumor are marked on the map and only those areas are subsequently excised, thus sparing uninvolved tissue. In most cases fresh tissue is excised under local anesthesia and frozen sections obtained. Using this method four or more layers can often be taken in the

TABLE I

RESUME OF EXPERIENCE

Number of patients treated	41
Number of lesions treated	46
Type of lesions treated:	
Basal cell carcinoma	40
Squamous cell carcinoma	5
Atypical fibroxanthoma	1
Size of lesion clinically:	
Range 0.3-36.9 cm^2	
Average 3.76 cm^2	
Previous treatment:	
Curettage and electrodessication	14
Excision	7
Radiation	4
None	16

The authors are associated with the Department of Dermatology at The University of Iowa College of Medicine.

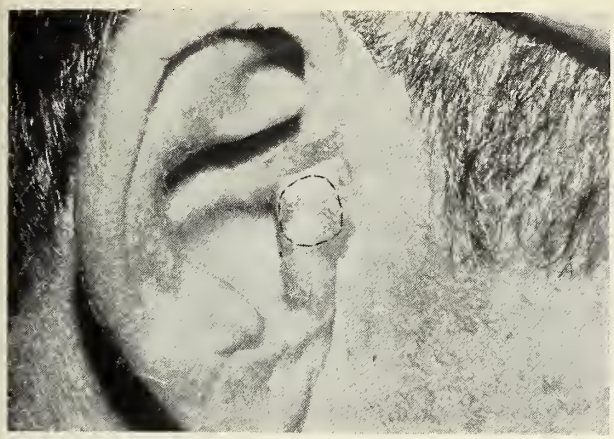

Figure 1. The tumor prior to surgery. The dotted line outlines the clinically apparent size of the tumor.

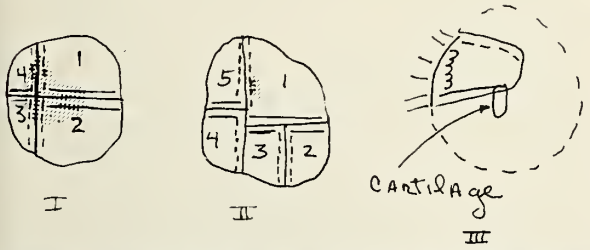

Figure 2. Map of the tissue layers. Shaded areas indicate the microscopic location of the tumor. Solid and dotted lines refer to the colors marking the edges.

same day. The excision is frequently completed in one or two days but extremely difficult cases may take up to a week. In most instances this procedure can be done on an outpatient basis.

ILLUSTRATIVE CASE

A 53-year-old caucasian male of German and Scotch ancestry was referred for treatment of a 1.5 x 2.0 cm basal cell carcinoma of the right tragus (Figure 1). The lesion had been present for several months and was gradually enlarging. He had a history of extensive sun exposure while working as a carpenter. Under local anesthesia the bulk of the tumor was excised and then three layers removed until a tumor-free plane was established (Figure 2). The tumor (which was much larger than suspected) extended to, but did not involve, the cartilage. Figure 3 shows the wound immediately after surgery. The wound was treated with daily cleansing and application of a topical antibiotic ointment. Two months later (Figure 4) the area was healed completely with a good cosmetic result. Examination six months after surgery revealed no evidence of recurrence.

Figure 3. Wound immediately after surgery, indicating the actual size of the tumor.

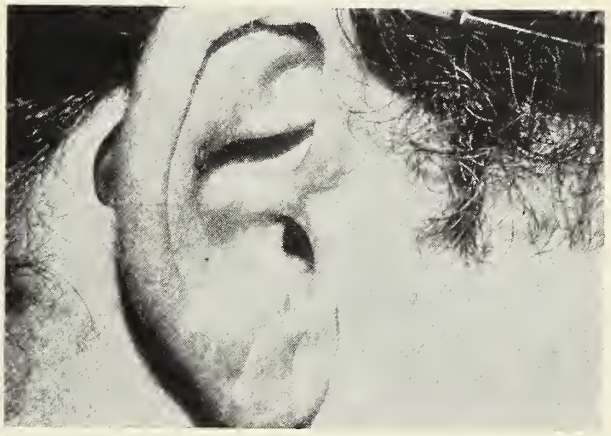

Figure 4. Wound two months after surgery, completely healed showing a good cosmetic result.

Although the follow up period has been brief there have been no recurrences to date. Healing has usually been complete in several weeks and the cosmetic result has been judged fair to excellent. There have been no serious complications. Plastic surgical revision is usually postponed for at least six months for two reasons:

1. If any residual tumor is present it should be apparent by that time.
2. When healing is complete the scar is often small and the patient often decides not to have additional surgery.

DISCUSSION

Skin cancers frequently have narrow outgrowths into their surrounding tissues which may extend along fascial planes, periosteum, perichondrium, lymphatics, blood vessels and nerves. Often these outgrowths are not clinically detectable and their incomplete removal leads to recur-

rence. Although histographic surgery is time consuming, tedious, and requires a technician to process the sections it provides a high level of certainty in determining the complete removal of malignant tissue.

The basic steps in the procedure are:

(1) Removal of the bulk of the tumor by tangential excision;

(2) Excision of layers including the lateral and deep margins of the tumor;

(3) Dividing this layer into small blocks, marking the edges and mapping the lesion;

(4) Microscopic examination of frozen sections cut from the undersurface of the excised layer, and

(5) Repeating steps (2) through (4) in the areas where the tumor is seen until a microscopically proven tumor-free plane is established.

This method may be the treatment of choice for tumors in certain difficult locations, tumors with vague clinical margins, with morpheaform histologic type or if recurrent after previous treatment. In fact, it may be the only method that can provide definitive treatment for certain patients. In cases where the lesion is well defined, however, curettage and electrodesiccation, excision, or radiation will likely remain adequate modes of treatment.

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TABLE II

PREDISPOSING FACTORS

1. All 41 patients were Caucasians and nearly all had fair complexion, were of northern European descent and had a history of extensive sun exposure.	
2. Age (years):	
Range	31-89
Average	63.2
3. History of radiation to the general area of the lesion	5 (12%)
4. Home State:	
Iowa	36 (88%)
Illinois	2
Kansas	2 (12%)
Louisiana	1
5. Pre-existing lesion (Actinic keratosis, epidermal nevus, etc.)	12 (29%)
How the patients presented (reason for referral):	
Recurrent lesion	18
Difficult location	5
Vague margins clinically	7
Histologically morpheaform	5
Greater than 2 cm in diameter	17

TABLE III

TECHNIQUE USED

Fixed tissue	4
Fresh tissue	43
Both	1
Number of layers needed:	
Range	1-7
Average	3.5
Number of sections:	
Range	2-60
Average	13.5

MEDICAL MISCELLANY

TO SPECIALTY GROUPS . . . Listings of Iowa physicians by specialty have been distributed by the IMS to officers of medical specialty organizations for their reference use.

OPPOSE PENAL PLAN . . . The IMS Executive Council July 29 sustained a recommendation of the Committee on Psychiatric Care opposing the housing of penal inmates in one section of the Mt. Pleasant Mental Health Institute. Letters on this subject were authorized to be sent to Governor Ray and Social Services Commissioner Burns.

INTERIM STUDY . . . Now becoming active is the Interim Committee to Study Cost and Availability of Insurance which was created by the 1976 General Assembly. The committee is specifically instructed to include medical liability insurance among its topics. The IMS has filed a preliminary statement with the Committee and expects to participate in its further deliberations.

ORGAN DONATION . . . Society representatives have conferred recently with officials of the Department of Transportation and the Kidney Foundation on implementation of the new law which authorizes use of the driver's license to advise of an organ donation. A sticker will be placed in a boxed area on the license to let it be known that an organ is being contributed.

Lack of Thyroxine Binding Globulin (TBG) in Pregnancy—A Case Report

FRANK J. ZLATNIK, M.D., and
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Iowa City

Described here is a pregnant patient with a condition involving binding proteins—an apparent congenital lack of TBG. Because of her thyroid history she received medication throughout the balance of her pregnancy. She followed a normal antepartum course.

THE THYROID HORMONES, thyroxine (T_4) and triiodothyronine (T_3), circulate in the blood largely bound to plasma proteins. The most important of these is thyroxine binding inter-alpha globulin (TBG) which binds about 60% of circulating T_4.[1] T_4 is also bound to thyroxine binding prealbumin (TBPA) and to albumin. T_3 binds more loosely to TBG and not at all to TBPA. The ratio of T_4 to T_3 in the blood is about 20 to 1; the ratio of bound to free T_4 is about 2000 to 1. Despite this quantitative importance of binding, the levels of free or unbound thyroid hormones are considered to be the determinants of an individual's thyrometabolic status. On the other hand, most chemical tests of thyroid function directly or indirectly measure total hormone levels. These measurements generally correlate with the patient's level of thyroid function, however, there are circumstances where abnormal levels of binding proteins can cause apparently "abnormal" thyroid function test results in euthyroid patients.

Physicians who care for women are familiar with the estrogen induced elevation of TBG resulting in an "elevated" PBI or T_4 by Column in a pregnant patient or in one taking oral contraceptives. We have recently cared for a patient with a different condition involving binding proteins—an apparent congenital lack of TBG. This patient and her son form the basis for this report.

Dr. Zlatnik is associated with the Department of Obstetrics and Gynecology at The University of Iowa College of Medicine. Dr. Jordan is with the United States Air Force located at U.S.A.F. Hospital Hahn, Hahn Air Base, Germany.

CASE REPORT

V. S., a 25-year-old married white woman, GIPO, registered for antepartum care at 9 weeks gestation. Her past history was of interest in that she had been treated with thyroid hormones from ages 5 to 21. The medication was prescribed as a result of an evaluation for obesity. No other family members had thyroid disease or were taking thyroid medication to the patient's knowledge. She stopped her thyroid medication at age 21 on her own and did not resume it. She had no history of hepatic or renal disease and was taking no medicines. The patient's physical examination was consistent with a 9 week intrauterine pregnancy and was otherwise normal. Specifically, there were no signs of thyroid dysfunction; she was not obese.

Routine laboratory work was normal except for a positive urine culture. Because of her history of a thyroid disorder, a T_4 by Column and a Radioactive T_3 Resin Uptake Test were obtained. The results of these tests and repeated ones are shown in Table I (in Parentheses).

Because of our uncertainty as to the significance of the reported results and of the potential effects of untreated hypothyroidism on the pregnancy, the patient was started on sodium levothyroxine* after the first thyroid function tests were reported. The dosage was increased to 0.3 mg per day which was maintained for the remainder of the pregnancy.

* Synthroid-Flint Laboratories.

TABLE I

THYROID FUNCTION TEST RESULTS OF CASE REPORTED

	T_4 By Column (Micrograms % Iodine)	T_4 By Competitive Protein Binding (Micrograms % Iodine)*	Radioactive T_3 Resin Uptake %	Free T_4 (Nanograms %)*	TBG (Micrograms T_4 Iodine Binding Capacity/100 ml.)*
Normal values	2.9-6.5 (Pregnancy: 4.8-9.6)	3.3-7.8	25-35 (Pregnancy: 17-25)	1.4-2.6	10-26
Patient V. S.	(0.5; 1.6)	1.8	(35.8; 40)	1.45; 1.4	Undetectable X2
Husband R. S.	5.0	4.4	—	1.6	17
Son B. S.	—	2.5	—	2.0	Undetectable

* Performed by BIOSCIENTIA—Ingelheim, West Germany

The patient's asymptomatic bacteriuria was successfully eliminated by antibiotic therapy. The remainder of her antepartum course was normal.

Spontaneous labor ensued at 41 weeks gestation and after a 7½ hour first stage and 23 minute second stage, a 3440 gm boy was delivered spontaneously, OA, over a midline episiotomy under local anesthesia. Although depressed at birth, Apgar Score 4 at 1 minute and 7 at 5 minutes, the baby responded to routine resuscitative measures and did well neonatally. Mother and baby were discharged from the hospital on the third postpartum day.

Because, at this point, we suspected the mother suffered from a deficiency of TBG and that this was the probable explanation of her unusual thyroid test results, her thyroid hormone therapy was discontinued. Several months after delivery, free T_4 (FT_4) and TBG determinations confirmed the diagnosis (See Table I). She remains clinically euthyroid off thyroid medication. The patient is sex chromatin (X body) positive. Her blood urea nitrogen and serum protein electrophoresis are normal.

Her son, B. S., has developed normally. His tests also reveal a complete lack of TBG. Her husband, R. S., has normal TBG levels (Table I).

There is no history of consanguinity in the patient's family. Other family members were unavailable for testing.

TABLE II

EXPECTED THYROID FUNCTION TEST RESULTS AT VARIED TBG CONCENTRATIONS

	PBI T_4 By Column T_4 By Competitive Protein Binding	Radioactive T_3 Resin (or RBC) Uptake	Free T_4
Increased TBG, e.g. pregnancy, estrogen Rx, etc.	↑	↓	N
Decreased (or absent) TBG, e.g. genetic congenital absence, androgen Rx, etc.	↓	↑	N

N—Normal. ↑—Increased. ↓—Decreased.

DISCUSSION

The amount of bound thyroid hormones in the blood varies directly with the concentration of binding proteins. For example, in the normal euthyroid pregnant woman, estrogen induces an elevation of TBG. By the law of mass action, additional free T_4 then binds to TBG. This resultant fall in the critically important FT_4 level results through central homeostatic mechanisms in increased pituitary stimulation of the thyroid gland to increase thyroid hormone secretion, bringing the FT_4 level back to normal. Thus total T_4, bound and unbound (as measured in the PBI or T_4 by Column determinations), is increased, but the FT_4 remains normal and the individual remains eumetabolic. This picture is oversimplified, as T_3 is not considered. Although it is present in much smaller amounts than T_4, it is more potent, is less tightly bound to plasma proteins, and is considered to be of equal metabolic importance.

In addition to pregnancy, TBG is elevated by estrogen therapy and genetically in certain patients. The Radioactive T_3 Resin Uptake Test, an indirect measure of unfilled binding sites in a patient's serum, gives low values in euthyroid patients with these conditions, since with elevated TBG levels more binding sites are available and less of the test hormone binds to the resin.

TBG levels are decreased by androgen therapy,

in patients with the nephrotic syndrome (urinary loss), and in certain patients with hepatic disorders (impaired synthesis). TBG can be decreased or absent on a genetic basis as in the case reported. With diminished or absent TBG, the opposite circumstance to that of the normal pregnant woman pertains. The FT_4 level is normal. Since there is decreased ability of the patient's plasma proteins to bind thyroid hormones, the total T_4 level is low, as measured by the PBI or T_4 by Column, and the T_3 Resin Uptake Test gives high values. Table II summarizes the effect of TBG alterations on these thyroid function tests.

Congenital lack of TBG is generally thought to be inherited as an X-linked dominant.[2] Our patient is one of few women reported with a complete lack of TBG.[3] Whether this represents unusual expressivity of an X-linked gene in this patient or whether the inheritance here will ultimately prove to be on an autosomal dominant basis is uncertain.

Since the FT_4 is normal in these patients, they are eumetabolic. The importance of this benign condition of binding protein lack lies in its recognition. If, in the evaluation of a patient's thyroid status, the PBI or T_4 by Column and Radioactive T_3 Resin Uptake Test point in opposite directions, an abnormality of binding proteins should be suspected. The Free Thyroxine Index (T_7), which is the calculated product of the T_4 and T_3 Uptake test results ($T_7 = T_4 \times \frac{T_3 \text{ Uptake}}{100}$) will be normal in euthyroid patients with these conditions. The effect of the abnormal amount of TBG on the two tests is in opposite directions and is cancelled out by multiplication of the two test results. The situation can be precisely defined by determination of the FT_4 and TBG levels. Unnecessary hormone therapy can thus be avoided.

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Morbidity Report for July, 1976

Disease	July 1976	1976 to Date	1975 to Date	Most July Cases Reported From These Counties
Amebiasis	1	33	12	Chickasaw
Brucellosis	1	10	—	Dubuque
Chickenpox	45	8966	6612	Dubuque
Conjunctivitis	6	1476	856	Jefferson
Gastrointestinal viral inf.	35	16262	14690	Johnson, Pottawattamie
Hepatitis				
A (infectious)	18	86	98	Polk, Pottawattamie
B (serum)	4	54	58	Polk
Unspecified	2	11	23	Franklin, Howard
Impetigo	3	485	326	Buena Vista, Dubuque, Jefferson
Infectious Mononucleosis	17	676	798	Buena Vista, Johnson, Polk
Influenza-like illness	3	32946	36126	Buena Vista, Johnson
Mumps	7	1191	994	Pottawattamie
Pediculosis	14	273	205	Buena Vista
Pneumonia	15	689	725	Scott
Rabies in Animals	9	80	70	Scattered
Ringworm, body	5	170	—	Scattered
Ringworm, scalp	1	19	—	Pottawattamie
Rubeola	1	18	9	Woodbury
Salmonellosis	11	68	99	Scattered
Scabies	5	430	258	Polk
Shigellosis	5	58	43	Pottawattamie
Streptococcal infections	344	10958	6690	Johnson, Pottawattamie, Scott
Tuberculosis, total ill	11	62	78	Woodbury
Tuberculosis, bact. positive	11	56	32	Woodbury
Venereal Diseases				
Gonorrhea	646	3883	3768	Black Hawk, Linn, Polk, Scott
Syphilis	35	198	175	Black Hawk, Polk, Scott

Laboratory Virus Diagnosis Without Specified Clinical Syndrome
Coxsackie B2 Isolated 1, Herpes Simplex 12

Editorials

M. E. ALBERTS, M.D., Scientific Editor

AMA ANNUAL CONVENTION

The activities of many persons, each with varying interests, provides a kaleidoscope of contrasts. Such was the recent AMA Annual Convention in Dallas. An adequate description of the convention is difficult, yet perhaps I can develop a vignette of the entire scene.

Dallas is a wonderful city, if you need not be outside at mid-day in late June. The 98° heat helped to make attendance at the various air-conditioned sessions more wise than seeking other pursuits. The whole event could be described variously—a "side show," a political convention, a reunion, a social event, a learning experience, etc.

The delegates were at the convention to work; committee members deliberated on numerous important issues; the clinical exhibits and seminars attracted others, while the spouses were most likely lured by a well-known department store. I doubt that the average practicing physician realizes the hours of work done by their delegates. The individuals who represent us are not on a picnic or vacation trip. There are serious matters of business which demand their time and attention. Attendance at the general meetings of the House of Delegates was excellent. Many resolutions and reports were presented which ultimately required further consideration at reference committee meetings. The delegates handbook was nearly 2 inches thick—a massive assignment for our delegates.

The address of now retired AMA President Max H. Parrott adequately summarized the position of our organization in relationship to society in general and particularly to government. In summary, he declared that multifaceted problems face us, but together we can meet the challenges and present the truth about our position.

The exhibits at the convention center were varied and represented much effort. There was something for everyone—orthopedic demonstrations, presentations of new surgical techniques, introduction of many complex mechanical aids, as well as an information center for the physician seeking a different location for his practice. Many courses and clinical symposia were available to gain knowledge as well as Category I CME credit. The complexity and magnitude of the clinical exhibits were awesome.

The commercial exhibits of the drug and equipment suppliers varied from very informative to nothing more than side shows. It is amazing how some sales managers can be so narrow-minded—yet, perhaps P. T. Barnum was right.

The question must arise regarding the total value of an AMA convention. Does such a massive show provide for the needs of the average practitioner? I believe it does for several reasons. First, the business of the Association must be accomplished in a representative fashion. We elect our delegates; they then act in good faith on our behalf. We may not always agree with their decisions, but we must not forget that often they are privy to data of which we are unaware, and their decisions may have less bias or prejudice. I am certain there are very few physician delegates who would act in a totally self-serving manner.

A second reason for a convention so massive and complex is to provide the average practicing

(Please turn to page 387)

EDITORIALS

(Continued from page 386)

physician some insight into what others are thinking and doing. One might argue that other forms of communications such as video-tapes, recordings, journals and the like fulfill this need. Yet, the concerted efforts of the exhibitor are exhilarating to the viewer and can do no less than arouse curiosity. True, I may never do a cardiac catheterization, nor transplant a kidney, nor do a complete Doppler cerebrovascular examination, but it is interesting to know what others are doing. Naturally, the specialist will gravitate toward his area of endeavor, but many in attendance are neither specialists nor practitioners in large cities, and they desire the contacts with all modalities of medical practice. I must conclude that such a convention has a valuable purpose. It satisfies a need to project a favorable image for medicine. Kudos must be extended to all who labor so very hard to bring it to fruition, as well as to the delegates who take time from their practice to work for all of us—too often without thanks or recognition.—M.E.A.

ON 'BEEPERS'

Electronic technology has provided numerous ingenious instruments that were but dreams a quarter of a century ago. Calculators, computers, and various instruments of communication have phenomenal capabilities. Batteries of minute size and circuitry of microscopic dimension enable many of these instruments to be very small in size for ease of transport. One of these unique electronic mechanisms is the "beeper," that infernal gadget designed to summon the holder to the telephone.

For the most part, I am sure the beeper has a place in our world. I contend, however, that this instrument has been used to a point where it has become an aggravation to those for whom it has no direct value. There seems nothing so impolite or insulting to others as to have a beeper or mobile telephone interrupt a meeting, or sound off in a theater, or during church services. It is my belief no one is so important or indispensible that he must resort to such electronic gadgetry to the displeasure of those around him. How disconcerting it must be to a speaker to have his audience drawn momentarily away at irregular intervals by a most unpleasant electronic sound, much less than to have someone engage in conversation or receive a message audible to all around him. I liken this to no less than one person shouting to another across the room, "Hey, Joe, answer the phone!"

I have a proposal or two to make about beepers and mobile communication instruments. There seems to be a reluctance by their holders to turn the switch off, so perhaps the electronic genuises could modify these instruments for tactile or visual communication. Could not a little switch be provided to eliminate the audio message, and instead activate a tiny vibrator that could be felt, or a tiny light that could be seen without distracting others? Then, the receiver of the message could quietly excuse himself or await an opportune time to answer. If the instrument provides two-way communication there must be an easy method whereby the caller could be notified, perhaps by pressing a tiny button to indicate the receiver will call back later for the message.

Should the electronics industry find these suggestions insurmountable or not feasible, a last resort remains. I believe that common courtesy should dictate that beepers should be turned off during the presentation of the speaker, or those that anticipate a call be required to seclude themselves near the farthest door so they can quietly leave for the all-important message. I once had one of these electronic toys. It was like a noose around my neck, and I returned it to my answering service. I let my answering service know where I can be reached for true emergencies, and call them later for the other messages. I cannot recall any instance where such an arrangement has caused ill-will or hardship on any of my patients. However, if you wish to be united constantly to the telephone, consider the rest of us as well.—M.E.A.

LOAN PROGRAM NEARS QUARTER CENTURY

The Scanlon Medical Foundation/Iowa Medical Society has helped close to 350 aspiring physicians achieve their educational goals over its nearly quarter century of existence. The Foundation's student aid program was begun in 1953 under the impetus of the late George H. Scanlon, M.D. It was known at the outset as the Iowa State Medical Society Educational Fund.

In nearly 25 years since the Foundation was established approximately $600,000 has flowed through it on the way to deserving and qualified Iowans enrolled in medical school. These funds have continued to revolve with the repaid money circulated again in new loans to current students. In peak years as much as $60,000 has been entrusted to Iowans in the form of loans.

As a positive instrument of the medical profession, the Foundation is contributing significantly today to the maintenance and replenishment of the state's physician ranks. In the beginning the Foundation program was financed by a five-year assessment of Iowa physicians. Since then funds have been received voluntarily by the Foundation from Iowa practitioners and from various other sources. Certain monies—from county medical societies, medical specialty organizations and the Iowa Medical Auxiliary—have been loaned to the Foundation through the years for subsequent loan to medical students. There is more than $50,000 in this category. Wills, estates, memorials, etc., have also added to the resources.

As noted, the Foundation was first known as the Iowa State Medical Society Educational Fund. In 1964 the name was changed to Iowa Medical Foundation. And in 1968 the present designation was authorized to honor Dr. Scanlon, the organization's founder and a surgeon in Iowa City until his death in 1969.

Formally, the SMF/IMS is a non-profit corporation established to engage in, assist, further, promote, and contribute to the support of such charitable, educational and scientific activities and projects as are in general, either directly or indirectly, related to health or medicine.

With this corporate non-profit objective to seek, the Foundation has maintained as its principal activity the granting of loans to Iowans attending medical school. Loan applicants must be in good academic standing and must be deserving of assistance. The recipients are not required to attend medical school in Iowa, but most are students at the University of Iowa College of Medicine. A liberal repayment plan is available.

Those who receive Foundation loans tend to locate and practice in Iowa. A survey of loan recipients in recent years showed that better than half of those receiving Foundation funds remained in the state to pursue careers.

In addition to the medical student loan program, several other projects have received support from the Foundation. Included here are the Hawkeye Science Fair, the monthly Henry Albert Scientific Presentation in the JOURNAL OF THE IOWA MEDICAL SOCIETY, and the Baldridge-Beye Lecture at the IMS Scientific Session. Other support has been given activities in health care planning, employment of the handicapped, alcoholism education and sports medicine.

The Scanlon Foundation is guided by an 11-member Board of Directors. The 1976-77 Board is composed of A. J. Havlik, M.D., Tama; J. H. Kelley, M.D., Des Moines; Hormoz Rassekh, M.D., Council Bluffs; V. L. Schlaser, M.D., Des Moines; R. L. Wicks, M.D., Boone; G. L. Baker, M.D., Iowa City; R. E. Hockmuth, M.D., Iowa City; Ronald V. Saf, Des Moines; Ivan Johnson, Des Moines; Mrs. W. R. Bliss, Ames; and D. L. Taylor, Des Moines.

IN THE PUBLIC INTEREST

Medical Assistants

by BETTY EHLERT, CMA-A

"Change and Challenge—Then and Now," 20th Anniversary Convention Theme, Palmer House, Chicago, Illinois.

The Annual Meeting of the American Association of Medical Assistants will be at the Palmer House in Chicago from September 13-19. It will mark the Association's twentieth anniversary. Special events and displays will dramatize the progress made since AAMA became an official organization in 1956 in Milwaukee, Wisconsin. Iowa was one of 11 officially organized societies represented at that charter meeting.

AAMA members arriving in Chicago on September 11-12 may tour the city from the Lake Front to Chinatown, with ample time for trips to Chicago's renowned shopping areas.

The AAMA House of Delegates will convene on September 13.

Program plans include an exploration of the "quality of life" from infancy to old age; a discussion of the pharmaceutical industry as it affects the practice of medicine; collection procedures for the medical assistant, and architectural and emotional barriers which affect the handicapped. An informal exchange of ideas with peers will include roundtable discussions with persons in the major medical specialties. Other programs include: (1) a special session at which selected medical assistants will present original papers on subjects relating to the medical profession; (2) a workshop especially for students, and (3) a leadership training session with separate sessions for local, state, and national representatives. This year's CMA meeting will be devoted to training in the art of assertiveness. Special interest sessions have been planned for medical assistant educators.

The Continuing Education Committee will conduct a workshop on programs to meet AAMA's proposed standards for Continuing Education Unit (CEU) credit. In addition, workshops on Guided Study, Membership, and Public Relations are planned.

The CMA dinner will be Thursday night with awards given to CMA's who have passed the examination this year.

James H. Sammons, M.D., Executive Vice President of the American Medical Association, will address the education session on "The Future of Health Care."

INVITATION TO LONDON

Seventy British medical secretaries attended the 1973 AAMA convention in Washington, D.C. This year, AAMA members have been invited to London for their Association of Medical Secretaries meeting, the first international conference to be held. Colleagues in London are correlating programs and scenic tours for their guests, with the intention of repaying some of the hospitality which they enjoyed as AAMA guests in Washington, D.C.

The flight to London is scheduled to depart from Chicago September 19 following the annual meeting. General sessions of interest to both British and American registrants are planned, with international sessions that include physicians, medical assistants and secretaries from several different countries.

About IOWA Physicians

Dr. Gregory Sears has joined the staff of Foster Oral Surgery Group in Waterloo. A Davenport native, Dr. Sears earned the D.D.S. degree at U. of I. and the M.D. degree from University of Nebraska School of Medicine in Omaha. Dr. Sears completed his internship at the University of Nebraska this spring. . . . **Dr. R. Dennis Bastron** has been promoted to professor in the Department of Anesthesia at U. of I. College of Medicine. Dr. Bastron received the M.D. degree and completed his residency in anesthesia at U. of I. He is the son of **Dr. and Mrs. Harold C. Bastron** of Red Oak. . . . **Dr. James Burke** and **Dr. Milton Van Gundy** have joined **Dr. Edward Jacobs** in family practice in Marshalltown. Both physicians received the M.D. degree at University of Kansas and had their family practice residencies at Mercy-St. Luke's in Cedar Rapids. . . . **Dr. Larry Lawhorne** has joined **Dr. Keith Mills** in family practice in Lone Tree. Dr. Lawhorne received the M.D. degree at University of Virginia School of Medicine in Charlottesville, Virginia, and completed his family practice residency at University Hospitals in Iowa City.

Dr. John D. Rhoades and **Dr. Donald H. Reyerson** recently became associated with the Kersten Clinic in Fort Dodge. Dr. Rhoades received the M.D. degree at U. of I. College of Medicine and completed his family practice residency at St. John's Hospital in St. Paul, Minnesota. Dr. Reyerson received the M.D. degree at U. of I. College of Medicine and served his pediatric residency at Mayo Clinic. . . . **Dr. Donald D. McCabe** has opened a pediatrics practice in Burlington. A native of Mt. Pleasant, Dr. McCabe received the M.D. degree at U. of I. College of Medicine and served his pediatric residency at Vanderbilt University in Nashville, Tennessee. . . . **Dr. C. A. Trueblood** recently celebrated 40 years of medical practice in Indianola.

Dr. Francois M. Abboud was recently named head of Department of Internal Medicine at U. of I. College of Medicine. Prior to joining the U. of I. College of Medicine faculty in 1960, Dr. Abboud had three years of specialty training at Milwaukee County Hospital and served two years as an American Heart Association Fellow and Research Associate in Cardiology at Marquette University.

Dr. Subhash C. Sahai has opened a family practice in Webster City. Dr. Sahai received the M.D. degree at U. of I. College of Medicine and completed his residency at Broadlawns Polk County Hospital in Des Moines. . . . **Dr. Orman Nelson,** D.O., Jefferson, recently received the AMA Physician's Recognition Award following completion of three-year continuing medical education program. . . . **Dr. Charles Caughlan** has joined Internal Medicine Associates in Mason City. A native of Council Bluffs, Dr. Caughlan received the M.D. degree and served his internal medicine residency at U. of I. College of Medicine. . . . **Dr. R. W. Thorbrogger** has joined the Spirit Lake Medical Center. A family practitioner, Dr. Thorbrogger received the M.D. degree at U. of I. College of Medicine and completed one-year of postgraduate training at McKennan Hospital in Sioux Falls, South Dakota. . . . **Dr. W. J. Robb,** Cedar Rapids, is new president of Mid-Central States Orthopaedic Society, Inc. . . . **Dr. Ronald M. Larsen** joined the staff at the Kersten Clinic in Fort Dodge July 1. Dr. Larsen received the M.D. degree at U. of I. College of Medicine and completed a psychiatric residency at Washington University School of Medicine in St. Louis, Missouri.

LIST YOUR WANTS

DOCTORS—THE NEXT MOVE IS YOURS . . . Midwest Medical, Inc. will provide you with more information about each opportunity than you have ever imagined possible. For the first time you can visually preview the Community and Medical Facilities of over 80 opportunities in the Upper Midwest, at ONE location, Saves you time, expense, and frustration. For a thorough appraisal of all factors involved, please accept our invitation to call. For discreet and confidential assistance contact M. A. Cornwall, M.D., MMI's Medical Director, or write: Midwest Medical, Inc., Lakeland, Minnesota 55043. 612/436-5161. Locum Tenens opportunities always available.

ANESTHESIA DIRECTOR (M.D.)—455-bed hospital to 705 beds in 1977 (suburban Omaha). Direct 3 anesthesiologists and 7 registered nurse anesthetists; serve on Hospital's Medical Staff Executive Committee; 750 surgical cases per month; outpatient surgery; hospital based specialists; neonatology, pulmonary disease, cardiology, emergency medicine, pathology and radiology; affiliated education programs with two medical schools in the City (Nebraska and Creighton); guaranteed remuneration; malpractice insurance provided; candidates must be a Diplomate or eligible. Annual report and other health care corporation information available. Write or call James E. Johnson, Chief Executive Officer, Archbishop Bergan Mercy Hospital, 7500 Mercy Road, Omaha, NE 68124. 402/398-6024.

LE MARS, IOWA, NEEDS 3 FAMILY PHYSICIANS now to provide medical service to a county-seat community of 8,500 and a medical area of 25,000. Three doctors now practicing need immediate help because of the retirement of colleagues. You have your choice of joining existing clinics or establishing your own practice, fully supported by present physicians. New 44-bed municipal hospital entirely paid for by local funds will open this spring. Excellent public and parochial school systems, 4-year accredited liberal arts college, rich agricultural area, variety of diversified clean industries, modern progressive business district and excellent recreational facilities are available for your enjoyment and relaxation. Le Mars is centrally located in northwestern Iowa within easy driving distance to the metropolitan areas of Sioux City, Omaha, Des Moines, Minneapolis and Sioux Falls. If you are looking for quality of life in a wholesome environment, we think you will be interested in Le Mars. For further information contact: Floyd Valley Medical Manpower, 115 Plymouth St. NW, Le Mars, Iowa 51031, phone 712/546-5306.

FOR SALE—Office equipment, surgical instruments for eye, ear, nose and throat. House suitable for doctor's office in Oelwein, examining chairs, tonometers, diathermy machine, copying machine, lens cabinet, stools, desks, chairs, frame bars, contact lens cleaner, treatment cabinet with suction machine. Phone Oelwein 319/283-3464 or write Mrs. A. E. Berry, Box 231, Oelwein, Iowa 50662.

GP-FP wanted for progressive county seat town. Close to Metropolitan Iowa communities. Excellent schools, churches. Good fishing, hunting. Contact John L. Mochal, M.D., or Richard A. Myers, M.D., 801 1st Street East, Independence, Iowa 50644. Phone 319/334-2541.

OBSTETRICIAN-GYNECOLOGIST wanted to join two-man department, established 19-man multispecialty group in Central Iowa. Immediate financial partnership. Outstanding fringe benefits. Regional hospital, excellent schools, recreational facilities. Write No. 1515, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

WANTED—FAMILY PRACTITIONER to join 8-man multispecialty group. Excellent clinic and hospital facilities. Unusually progressive small community in which to live and raise a family. Excellent salary and benefits, partnership in twelve months, liberal vacation and meeting time. Contact Richard A. Callis, Administrator, McCrary-Rost Clinic, Lake City, Iowa 51449. Telephone 712/464-3194.

INTERNIST—Excellent immediate opportunity for practice of general internal medicine. Only two hours from Minneapolis. $40,000 first year with early partnership and corporate benefits. Good school and art museum. Close to lake. Congenial, multispecialty in pleasant northern Iowa. Phone 515/423-0244 collect.

WELL ESTABLISHED MEDICAL AND SURGICAL GROUP desires to expand the Family Practice Department from four to six family practitioners. Salary first year—partnership second. No buy-in required. Check this one—it's an excellent opportunity in a good stable economic location with plenty of social, cultural and recreational activities. Contact either G. W. Glenn, Business Manager, or Robert A. Weyhrauch, M.D., 1125 West Fourth Street, Waterloo, Iowa 50702. Phone 319/234-1541.

PRACTICE AVAILABLE—Open-ended opportunity for a General/Family Practitioner, with or without surgical involvement. Full-time physician is needed, though part-time or "Locum tenens" may be considered. The community is rural, with a population of approximately 3,000, and a service area of 8-10,000, located 120 miles Southwest of Minneapolis. It has a diversified economic base, underpinned by some of the country's most productive agricultural land. It has a broad range of religious, service and social organizations. The community currently has three general practitioners, one of whom is semi-retired, averaging 60 years of age. It has two clinics, a 34-bed hospital, a 60-bed nursing home and two pharmacies. A surgeon and pathologists from Mankato and a radiologist from Albert Lea make regular trips to the community and hospital. Medical specialists are available at Mankato (35 miles) and Albert Lea (25 miles). For additional information, contact D. H. Gilbert, Wells Municipal Hospital, 400-4th Avenue, S.W., Wells, Minnesota 56097. (507) 553-3111 or 553-5904.

WANTED—PRIMARY CARE PHYSICIANS ready to start practice? Why not investigate dynamic Racine County, site of Wisconsin's "Belle City of the Lakes?" Located between Milwaukee (½ hour) and Chicago (1 hour) on a peninsula in Lake Michigan. 174,000 community with one of the highest per capita income rates in the USA. Excellent private, public, and parochial schools and colleges; nine golf courses; excellent developed harbor for boating and sailing facilities; many small lakes, ski area, hunting and fishing. Close to Medical College of Wisconsin, Milwaukee, and University-Wisconsin Medical School, Madison; three modern general hospitals (656 beds); long-term rehabilitation facilities (Over 1,000 beds). For full information write Racine County Planning Council, 818 Sixth Street, Racine, WI 53403; or call 414/637-9737 collect.

FAMILY PRACTICE AVAILABLE NOW. Excellent location, high collection rate. Association with another physician for call, share expenses, etc. Lease, with opportunity to buy after a year, if agreeable to both parties. Write or call Robert M. Knox, M.D., 2255 73rd Street, Des Moines, Iowa 50322. Phone 515/276-4521.

OBSTETRICIAN-GYNECOLOGIST wanted to join two-man department, established 19-man multi-specialty group in Central Iowa. Immediate financial partnership. Outstanding fringe benefits. Regional hospital, excellent schools, recreational facilities. Write No. 1516, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

CARDIOLOGIST, UROLOGIST, ORTHOPEDIC SURGEON and OPHTHALMOLOGIST wanted to join established 19-man multispecialty group in Central Iowa. Outstanding fringe benefits including malpractice insurance, vacation, sick leave, life and health insurance, retirement program. Immediate financial partnership. Regional hospital, excellent schools, recreational facilities. Write No. 1517, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

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EQUIPMENT NEEDED—Young family practitioner starting solo practice in 1977 (March 1) interested in purchasing used equipment. Needs include microscope, minor surgical equipment, ECG machine, examining table, also appropriate business machines. Not interested in X-ray equipment. Please contact Don Flory, M.D., Broadlawns-Polk County Hospital, 18th & Hickman, Des Moines 50314; Telephone 515/283-2061.

FAMILY PRACTITIONER WANTED—Two family physicians with large hospital practice wish third associate who is board eligible to join busy family practice. Located in Waterloo, Iowa, a northeast Iowa community of 75,000. All records dictated on the Problem Orientated Medical Records System. Contact Ronald R. Roth, M.D., or Ronald D. Flory, M.D., 611 Black's Bldg., Waterloo, Iowa 50703.

OB-GYN, ENT, PEDIATRIC SPECIALISTS needed by 16-man multi-specialty clinic in university community of 50,000 in western Wisconsin; excellent retirement and fringe benefits; fine recreational opportunities; salary negotiable. Send curriculum vitae and references to: John R. Ujda, M.D., LaCrosse Clinic, 212 South 11th Street, LaCrosse, Wisconsin 54601.

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respond to one

According to her major
nptoms, she is a psychoneu-
ic patient with severe
xiety. But according to the
scription she gives of her
lings, part of the problem
y sound like depression.
is is because her problem,
hough primarily one of ex-
ssive anxiety, is often accom-
nied by depressive symptom-
logy. Valium (diazepam)
n provide relief for both—as
excessive anxiety is re-
ved, the depressive symp-
ns associated with it are also
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There are other advan-
es in using Valium for the
nagement of psychoneu-
ic anxiety with secondary
pressive symptoms: the
chotherapeutic effect of
lium is pronounced and
pid. This means that im-
provement is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

veillance because of their predisposi-
n to habituation and dependence. In
gnancy, lactation or women of child-
ring age, weigh potential benefit
inst possible hazard.

cautions: If combined with other psy-
tropics or anticonvulsants, consider
efully pharmacology of agents em-
yed; drugs such as phenothiazines,
cotics, barbiturates, MAO inhibitors
l other antidepressants may potentiate
action. Usual precautions indicated in
ients severely depressed, or with latent
pression, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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President's Page

In 1956, the American Association of Medical Assistants was chartered. There were some among our number who viewed this launching with suspicion, muttering darkly that here was the birth of a union which would soon create havoc in medical offices everywhere. How baseless were their fears! The devoted and competent women who brought this Association into being had only one simple goal—to do their jobs better. In pursuit of this ambition they have increased their numbers to almost 18,000 nationwide with more than 500 local chapters in the 47 state societies. With the encouragement and guidance of the AMA, the AAMA has established certification programs for its members, accreditation of medical assisting programs in community and junior colleges, as well as in vocational institutions. It fosters continuing education for its members, and sponsors a scholarship fund for students of medical assisting.

It has been my personal privilege and pleasure to encourage, as best I could, the growth of this remarkable organization in Iowa. They have bestowed upon me an honorary membership which I cherish. All of us bosses are deeply indebted to the intelligent, devoted, and tireless helpers without whom we could not function.

This is the twentieth birthday of the American Association of Medical Assistants. The Iowa Medical Society salutes them and offers its gratitude for work well done.

James F. Bishop, M.D.

James F. Bishop, M.D., President

P.S. Whatever your political beliefs, be sure to express them at the polls next month. Voting is an American privilege we should consider a duty.

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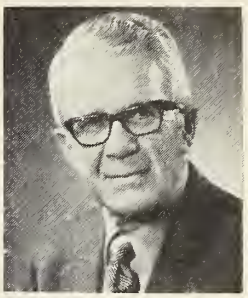
The Question Box



by OTIS D. WOLFE, M.D.

ELECTION OBSERVATIONS

Otis D. Wolfe, M.D., is in the private practice of ophthalmology in Marshalltown. He is a past-president of the Iowa Medical Society and past chairman of the Iowa Medical Political Action Committee. His observations here are related to the impending elections.

As a respected and veteran observer of the governmental and political scene, what is your brief analysis of the 1976 presidential race?

At this time (September 7) it would seem to be a sweeping victory for Mr. Carter. The debates, an international incident, or a political boo-boo, could change the picture.

Political campaigning reaches a high point this month. In your judgment, what's the most objective way to decide on a candidate?

The issues. However, Mr. Carter is elusive on the issues and Mr. Ford doesn't articulate them well. A Democratic administration superimposed on a Democratic congress, indebted to organized labor, spells national health insurance. This could be very ominous for physicians in private practice.

The state legislative races sometimes sacrifice notoriety in a presidential year. Do you regard them worthy of close attention by physicians?

In recent years, medicine has faced more health issues in the state legislature than in the U. S. congress. Attention to the state legislature has never been more important to physicians. A national health insurance program would probably have considerable state input, and communications would be critical to the success of the program. Legislators "listen" best to those who helped in their campaign.

What, if any, political education should the Iowa physician engage in, in terms of his contacts with his patients?

It isn't easy for the physician to be "political," especially in his office. A politically militant physician is apt to offend his patient or appear more interested in politics than in his patient's welfare. However, a soft sell has enormous impact. People respect the physician's opinions and are influenced by them. Sometimes a picture of a candidate in the physician's office gives an opportunity for the patient to ask the doctor's opinion.

MEDICAL MISCELLANY

MANPOWER RECRUITMENT . . . A three-day conference on "How to Succeed in Recruitment of Health Manpower" will occur November 15-17 at the Ramada Inn Downtown in Des Moines under sponsorship of the Office of Planning and Programming Health Manpower Project. The session is open to all interested community leaders and invitations will be sent to county medical society presidents.

AUGUST OPENING . . . A Family Practice office has been opened in a remodeled area of the U. of I. Children's Hospital. Included are nine faculty and staff offices and six examination rooms. The patient clientele will be comprised of 300 Iowa City and Johnson County families now enrolled in the Family Practice office at Oakdale. The Oakdale office will continue to operate for the present.

State Department of Health

INFLUENZA SURVEILLANCE ALERT

The Disease Prevention Division of the State Health Department has expanded its surveillance program to include monitoring school and industrial absenteeism as well as hospital admissions for febrile upper respiratory infections. This program will involve 17 of the larger communities of Iowa. It will constitute a sentinel system to detect the presence of influenza before extensive involvement occurs in communities of the state. In addition, the State Hygienic Laboratory is routinely screening throat washings and blood specimens from University of Iowa students for the presence of influenza virus. These programs, while beneficial, do not supplant the essential information which is transmitted directly by primary care physicians in Iowa to the State Health Department and State Hygienic Laboratory. Therefore, physicians are encouraged to be observant for influenza, attempt laboratory studies when appropriate and notify local or State Health Departments of suspected outbreaks.

Early recognition of influenza may be difficult since its signs and symptoms are common to other diseases. It is usually suspected when one observes a sharp increase in patients with typical complaints of painful dry cough, muscle aches, weakness, moderate fever and headache, in the absence of gastrointestinal signs. Laboratory studies may be helpful in this situation and their use is encouraged.

Because of limitations of the State Hygienic Laboratory, only 4-6 patients with typical illness should be selected for laboratory studies. Acute and convalescent blood specimens collected two weeks apart provide meaningful results. The first blood specimen preferably is collected soon after onset of illness. Throat washings for virus isolation may be collected early and should be kept frozen. In the unfortunate event death follows the onset of suspected influenza, lung tissue and trachea may be collected (frozen) for virus isolation. Please contact the laboratory in advance for other advice regarding virus isolation.

SWINE VACCINE DELIVERY . . . Reports to the State Department of Health indicate both monovalent and bivalent flu vaccine will be coming into Iowa on an incremental basis during October. It is expected that 419,040 doses of bivalent will be received with 403,500 doses of monovalent. The first 27,000 doses of bivalent vaccine will be directed to the nursing home population with another 100,000 doses intended for the use of physicians in vaccinating the elderly and debilitated who live in their own homes.

Surveillance . . . In Brief

1. Influenza is a "clinical-epidemiologic" diagnosis. Its typical symptoms include fever, malaise, general body aches, dry cough in the absence of gastrointestinal signs.
2. Collect specimens soon after onset from 4-6 typical patients in an outbreak of flu-like illness.
   a. Paired serum specimens may be submitted to the State Hygienic Laboratory for serologic tests.
   b. Throat washings (frozen) may be submitted for virus isolation. (Notify—Virology Section, State Hygienic Laboratory in advance. Tel. *#319-353-5990).*
3. Advise local and/or State Health Departments of suspect outbreak.

FLU SURVEILLANCE HOT LINE
800-362-2737

Morbidity Report for August 1976

Disease	Aug. 1976	1976 to Date	1975 to Date	Most August Cases Reported From These Counties
Amebiasis	1	34	13	Winnebago
Brucellosis	2	12	12	Cerro Gordo, Dubuque
Chickenpox	16	8982	6642	Scattered
Conjunctivitis	12	1488	886	Scattered
Encephalitis due to Herpes simplex	2	—	—	Johnson, Polk
Gastrointestinal viral inf.	46	16308	14784	Scattered
Giardiasis	1	17	12	Johnson
Hepatitis				
A (infectious)	5	96	108	Crawford
B (serum)	5	64	69	Scattered
Unspecified	3	14	24	Scattered
Histoplasmosis	2	14	—	Polk
Impetigo	6	451	368	Benton, Buena Vista, Dubuque, Jones
Infectious mononucleosis	13	689	814	Johnson, Linn, Polk
Influenza-like illness	9	32955	36222	Scattered
Meningococcal meningitis	1	9	12	Polk
Meningitis, bact.	1	3	—	Carroll
Meningitis, due to *H. influenza*	1	6	—	Wapello
Meningitis, type unspec.	1	4	—	Des Moines
Mumps	4	1195	1001	Black Hawk, Muscatine, Pottawattamie
Pediculosis	5	278	215	Scattered
Pinworms	6	29	34	Polk
Pneumonia	28	726	762	Scott
Parasitic infestations	1	1	—	Kossuth
Rabies in animals	19	99	80	Scattered
Ringworm, body	3	22	—	Montgomery, Palo Alto
Rocky Mountain spotted fever	2	3	—	Clinton, Polk
Rubella (German measles)	4	87	—	Cerro Gordo, Dubuque, Shelby
Rubeola (measles)	2	37	589	Shelby, Wapello
Scabies	15	445	283	Polk
Salmonellosis	19	87	135	Scott
Streptococcal infections	232	11190	6933	Scattered
Trichuriasis	4	13	—	Appanoose
Tuberculosis, total ill	11	71	80	Scattered
Tuberculosis, bact. positive	19	62	—	Scattered
Venereal diseases				
Gonorrhea	537	4420	4436	Black Hawk, Polk
Syphilis	23	221	200	Scattered
Laboratory Virus Diagnosis Without Specific Clinical Syndrome				
Herpes simplex I				

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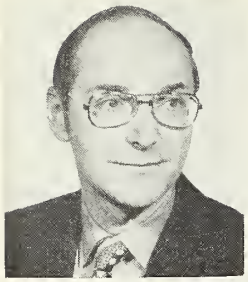

Educationally Speaking

by RICHARD M. CAPLAN, M.D.

'MEDICAL NEMESIS,' OR, READ A BOOK YOU WON'T LIKE

I find it curious to recommend you read a book you won't like. You should read this one, though, because it's important. It is a bitter medicine you need to help you be healthy. When I say "you," I mean all of us that constitute together the medical establishment. Ivan Illich [*Medical Nemesis* (The Expropriation of Health), Pantheon, New York, 1976] refers to us as the medical-industrial complex.

Why do I say you won't like it? First, because it's difficult to read. The difficulty lies partly in the profundity of ideas; partly in the author's universe of discourse (different from my own and I suspect from yours) that produces complicated sentences laden with the jargon you might suppose would come from a thinker whose academic training lies in history, sociology, philosophy and theology; and partly in the plethora of footnotes that are only partially parenthetical and therefore entice and challenge the eye and the mind and allow the pages to be turned more slowly than you expect. But more importantly, you won't like it because the message tramples on much of what I suspect you hold dear in your image of yourself, your professional colleagues, your life's work, and its place in our world.

If you have always wished for the power to see yourself as others see you, here is your chance. Here is at least one mirror to provide such a look. The good social critic, like the good artist, provides a view that we could not attain without his help. Illich sees a bigger picture than most of us usually see. To look at the big picture gives a perspective that is fresh and novel—and highly disturbing.

Medicine as a profession must take note of its being a boulder in a glacier of human and social affairs. We may understand the workings of the glacier but we cannot resist it. The insights into societal affairs that come to us by reading such as Illich can help us adjust more comfortably and beneficially to the glacial thrust.

Illich as a social critic is not totally "anti-medicine." He sees an important, and in his view, proper role for medical affairs. But he sees more vividly than most of us the failings and undesirable side effects of our modern industrialized and technological society. We have grown so adapted to our own ways and our society's usual perception of us and response to us that we fail to see much of the inappropriate quagmire of routine activities. Illich applies his "crap detector" to other major institutions of society, such as education, transportation, scientific methods and even other medical reformers. He even has scathing observations about the modern penchant (perhaps mania?) for continuing education. Maybe you'd agree with him about *that.*

If you concur with Socrates that the unexamined life is not worth leading, then Illich provides a context for your life that can help your professional existence be more meaningful.

My opening metaphor, that you should read Illich because he is a medicine that you need, would likely make Illich tear his hair. For he would condemn the metaphor as another example of the pernicious habit of medical people turning to the medical model as a remedy for an ill that must be cured with non-medical tactics in a non-medical arena.

"But medicine tells us as much about the meaningful performance of healing, suffering, and dying as chemical analysis tells us about the aesthetic value of pottery." If such a sentence produces some crackles of sparking cerebral synapses, as well as a surge of adrenalin, then have a go at *Medical Nemesis.*

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

SCIENTIFIC ARTICLES

The Health of Farmers

LARRY LAWHORNE, M.D.
Iowa City

The occupational diseases associated with farming are summarized here. Cuts and bruises are most plentiful, but fractures, puncture wounds and burns also occur. Noise, vibration, fumes and animals also present special problems. This summary is for reference use.

Lauren Soth in his book *Embarrassment of Plenty* made the following observation:

> *"Today a farmer must be more a mechanic than a weather prophet, more a scientist than a good judge of growing things. To be sure, modern agriculture is not all science. It is also an art of old."*

Medicine is also an "art of old." So in that respect, in addition to having a common concern for living things, physicians and farmers have strong bonds. This paper will consider a particular set of occupational diseases of paramount importance to those who deliver health care in the State of Iowa. Those processes either peculiar to or more prominent among farmers have only infrequently and often haphazardly been compiled in any form for the practicing physician. Consequently, this is an attempt to set forth the health status of farmers as we know it today.

None of this text will be devoted to pesticides since the problem of poisoning has not attained the magnitude in Iowa it has in other areas where man is in much more intimate contact with plants and fruits (re-entry concept). However, the practicing physician should know the basic pharmacology of the types of pesticides employed in his area, and in addition he is obligated to see that his office, as well as his area emergency room, are equipped to handle problems both secondary to pesticides and secondary to toxins such as anhydrous ammonia and other frequently used compounds. Part of the addendum by Dr. Donald Morgan will provide specific reference sources.

There are many other areas not touched on which may assume great importance in the coming years. The possible swine influenza outbreak, for example, pays homage to the fact that Iowa's biggest industry is becoming increasingly complicated. It suggests that all health care providers must keep up with what's happening on the farm to be competent "plant doctors." In addition, the whole concept of rural health care delivery is

Dr. Lawhorne is associated with the Institute of Agricultural Medicine of the Department of Preventive Medicine and with the Department of Family Practice, College of Medicine, University of Iowa. He is currently a family practitioner in Lone Tree, Iowa.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF OCTOBER, 1976.

HEALTH OF FARMERS— A SPECIAL REPORT

coming under scrutiny by state and federal authorities. It is important for Iowa physicians to provide meaningful input into the planning of modified systems of delivery of emergency as well as routine care.

PROBLEMS DUE TO PHYSICAL AGENTS

Accidents

Agriculture is said to be the third most hazardous occupation. The severity of farm machinery accidents contributes to this high ranking. And because U. S. agriculture is such a diverse mixture of environments, machines, toxins, and infectious agents, it is more difficult to describe the accident picture of the farmer in succinct terms, than it is the case of the assembly-line worker. The farmer is an innovator, and frequently a man in a race with time and weather. He works long hours, especially during planting and harvesting seasons, and he often tends to be his own mechanic, weatherman, doctor, and clergyman. These commendable attributes are at the same time risk factors, in that the tired, harried individual is much more likely to make the critical mistake that leads to an accident.

The majority of serious accidents is machinery-related, thus the type of accident will vary to some extent with the nature of the farming operation. Risk of accidents is higher in the youngest age groups and greater in hired hands than in farmers themselves. Fatal accidents are often associated with tractors, with tractor overturns having the highest case-fatality rates. Run-over and power take-off accidents also have a significant risk of death. While tractors may be associated with the most serious accidents, total accident frequency per hour of use is considerably higher with other farm equipment, in particular elevators, combines and balers. Wagons and corn pickers have lower, but still significant, associated accident rates.

The most frequent injury types are cuts and bruises, followed in descending order by fractures, sprains, puncture wounds, crushing injuries, burns and bites. Although fortunately not common, exposure of the eyes to anhydrous ammonia in use as fertilizer may result in blindness unless treated promptly by irrigation with water.

Local health professionals must be equipped to deal with these emergencies, whose difficulty is often compounded by the remoteness of the farmer from sources of care.

Vibration

In a Michigan study chronic back pain was identified as a major problem in a sample of 851 full-time farmers.[1] Back pain was reported in 21% of the sample, and in addition, two-thirds of those reporting changes in farming occupations for health reasons reported back pain as a factor. In that same study, arthritis was reported by 27% of the farmers. Sixty-seven of the 851 farmers surveyed reported that their work was hampered for 3,278 days in 1973 because of arthritis. The National Center for Health Statistics (NCHS Series 11, No. 20) reported rates of osteoarthritis in adults in various occupations and showed that men classified as farmers and farm managers had the highest rates for osteoarthritis, especially of the hands.

In a presentation to the Canadian Society of Agricultural Engineers in January, 1972, C. A. R. Dennis reported the incidence of the disc disease (specifically herniated nucleus pulposus) progressively increases with the increase in cultivated acreage of the farmer. Since there is no reason to believe that these farmers do more lifting than their counterparts with smaller farms, Dennis postulates that increased time spent on the tractor with the subsequent vibratory effects may play a role.

It is obvious that a farmer is subjected to a considerable amount of vibration through the operation of his large machinery as well as his collection of hand-held power tools. The vibratory effect may be due to the machine itself, the terrain over which the machine is traveling, or a combination of the two.[2]

Low ride-vibration frequencies in the 4-8 Hz range have been shown to produce whole body excitation. Other studies have demonstrated that in vertical vibration, viscera will resonate and perhaps more importantly operator performance will be adversely affected thereby increasing the likelihood of an accident.[2] In addition many agricultural machines or the parts which a worker must hold (e.g., gear shifts, steering wheels, and handles) can produce part-body vibrations of high frequency. It is well known that such circulatory disorders as Raynaud's phenomenon can ensue.

Standards are currently being developed for both whole-body and part-body vibration for general industry with modifications for agriculture.[2]

(Please turn to page 412)

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

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Design engineers have researched the vibration problem as it relates to operator placement and seating. Newer seats designed recently particularly for tractors have significantly improved the transfer of energy to the viscera and skeleton of the operator.

In summary, the total effect of vibration as well as the more mundane manual aspects of farm work (lifting in particular) have not yet been fully revealed. Intuitively, there must be marked effect on both the musculoskeletal system and the peripheral circulation as well as the viscera and there are some studies to support an association. However, definite causation has not been proved. In the meantime, the simplest of measures should be implemented to spare young farmers from the miseries of low back pain by stressing proper techniques of lifting and appropriate trunk muscle strengthening exercise.

Noise

The conversion of agriculture from animal power to machine power allowed the farmer to be more carefree with respect to where he stepped but added the new problem of hearing loss.

Noise pollution has been a well studied area in the agricultural field. A number of reports indicate that hearing impairments are common and they relate to machinery usage, the tractor being the main offender. One study concludes that hearing capabilities of male farmers are the poorest of all occupational groups.[3] The probability that this deficit exists on the basis of occupational exposure is supported by the fact that children do not have different audiometric findings according to place of residence.[4]

Although hearing losses may result from explosive blasts of intense sounds that cause tympanic membrane rupture or ossicle damage, the more common consequence is injury to the hair cells of the inner ear producing a sensoneural hearing loss.

A Michigan State study conducted in 1973[1] involved 80 full-time farmers ranging in age from 26-65 years with farming experience from 10-39 years. Significant hearing impairment (i.e., average of hearing threshold levels for both ears exceeding 26 dB at 1000, 2000, and 3000 Hz) was discovered in farmers between the ages of 19 and 41.5 years. The significance of the 25 dB figure is that this is the limit considered by NIOSH to impair speech communication. Even more disturbing was the discovery that the 58-65 year old group averaged a 40 dB loss at the 3 frequencies resulting in severe impairment in verbal communication. Presbycusis was controlled.

Another interesting finding from the MSU study,[1] which confirmed other reports, involved the trend for the left ear to exhibit an increasingly greater loss than the right ear at 4000 Hz. Some investigators have postulated that this is due to more intense exposure of the left ear to tractor exhaust noise when the right-handed farmer looks over his right shoulder while plowing, for example. The role of driving an auto or truck with the window open has been proposed as another contributor to increased exposure for the left ear.

Increased tractor operation time in this study[1] as in others correlated directly with increased hearing loss. Consequently, dairy farmers who had the least amount of tractor operating time had the most minimal hearing loss.

Preservation of hearing is realized by various devices (plugs, muffs, etc.) to protect the ears and by improved tractor cab design to absorb excess noise.

PROBLEMS OF THE RESPIRATORY SYSTEM

In the realm of respiratory disorders there are two entities that should be reviewed, namely farmer's lung and the less common silo-filler's disease.

Farmer's lung is the prototype of an ever-increasing number of disorders in which inhaled organic particles produce an allergic reaction in the peripheral respiratory tissues of nonatopic individuals.[5] Now termed either hypersensitivity pneumonitis or extrinsic allergic alveolitis, the syndrome was first described in 1713 and over the years became known as "hay shortness of breath." It was not until 1932, however, that the entity became more precisely defined as an acute respiratory process secondary to moldy hay or vegetable matter.[6] Since that time and especially over the past 5-10 years, many other organic particles have been implicated in the etiology of hypersensitivity pneumonitis, and some have been given rather picturesque names such as Maple Bark Stripper's Disease, Dog House Dis-

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ease, New Guinea Lung and Pigeon Breeder's Disease.

Clearly, hypersensitivity pneumonitis is different from an asthmatic response to an inhaled allergen. In the former, the inflammatory response takes the place in the alveoli and is usually considered to be a type III (arthus-type) hypersensitivity reaction; while in the latter, the inflammatory reaction, which is a type I reaction involving IgE, histamine and SRS-A, is set up at the level of the bronchi. It should be mentioned that, although most investigators still maintain that hypersensitivity pneumonitis is a type III reaction, there are a few experimenters who have presented data supporting a combination of types II (cytotoxic) and IV (cell-mediated) in the production of the tissue damage.[7]

Extensive laboratory investigations have shown specific antigens that reproduce the symptoms can be extracted from fungi present under certain conditions in stored hay, corn, oats and barley (but not from those in soybeans or peanut dust for some reason). The most common species of fungus is *Micropolyspora faeni,* although other thermophylic actinomycetes are less than six microns in size and can easily penetrate to the level of the alveoli.[5] It has been calculated that a farmer working in a moderately dusty environment of moldy vegetable matter may retain 750,000 spores in his lung each minute.[8] The dust in moldy overheated hay, for example, will be rich in the thermophylic actinomycetes which grow well at high temperatures of 40°-60°C and at a pH of 6 or higher. These high temperatures are produced by microbial growth in hay which is stored with a moisture content of greater than 29 to 34% water. Material harvested in rainy weather is most likely to provide temperatures, moisture and pH conditions conducive to fungal growth and spore formation.

Typically, the acute form appears in the farmer 4-6 hours after working with moldy material. He becomes dyspneic, coughs, and often experiences fevers, chills, muscle aches and lassitude. He, looks as though he has developed an influenza-like illness, and if inadequate historical information has been gathered, this may be the diagnosis. The symptoms will persist for 24 hours or so, and if re-exposure to the antigen is not forthcoming, any treatment will convey the illusion of success. A more subtle entity is the long-term exposure to smaller amounts of antigen under which conditions the farmer may present with slowly progressive complaints of dyspnea, weakness and mild weight loss. Physical examination reveals variations from an acutely ill-looking dyspneic, febrile patient with râles to a patient with a subjective feeling of breathlessness with no unusual findings. Chest X-ray may be normal or may show a fibronodular pattern with or without a few scattered infiltrates. Early in the disease process any chest X-ray changes are diffuse, but in the chronic form there is predilection for the upper lobes. Classically, pulmonary function studies will show a restrictive rather than obstructive pattern. CBC may be normal, but often there is a leukocytosis sometimes as high as 30,000 with a shift to the left. Eosinophilia is not a feature of farmer's lung. The sedimentation rate is elevated.

Diagnosis is made largely by history with physical examination and laboratory studies lending support. A helpful additional test is the farmer's lung serology which is basically an immunodiffusion test in which the patient's serum is placed in a central well surrounded by wells containing specific antigens implicated in farmer's lung. Precipitive lines indicate a positive result. There seems to be only a rough correlation between amount of precipitating antibody present in the patient's serum and the severity of the disease. However, the test must be interpreted cautiously. A number of patients who have been exposed but who are asymptomatic will have demonstrable antibody (perhaps up to 18% of exposed, healthy subjects have the antibody).[5] Conversely, a negative precipitin test does not exclude the diagnosis because the antibody titer probably falls rapidly with cessation of acute disease activity. Other diagnostic procedures such as skin tests and lung biopsies have only rarely been helpful. Allergen inhalation tests may be a useful diagnostic procedure in a particularly perplexing case.

Epidemiological data in farmer's lung are not in great abundance, especially in this country. Some estimates are that 10% of farmers are affected, and of course the vast majority of cases are in adult male farmers. Among occupational

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subgroups, dairy farmers are at greatest risk and especially those who do not have access to equipment and facilities for thorough drying and mechanical handling of vegetable material. The disease is most often seen during the late winter and early spring, and this is probably a consequence of the farmer's using material from the bottom of his silo or bin where conditions of moisture, temperature and pH are optimum for spore formation.[9]

Since June, 1965, the United Kingdom has under the National Insurance (Industrial Injuries) Act defined farmer's lung as an occupational disease. A number of U. K. clinical and serological studies showed the prevalence varied from 23 to 86 per 1000 depending on local variations in agricultural techniques. As of the present time, there are no comparable U. S. reports. In a postcard survey conducted by the University of Iowa's Institute of Agricultural Medicine at Oakdale, 118 physicians were contacted in a 10 county area south and east of Johnson County in an attempt to get some estimate of the number of cases compatible with acute or chronic farmer's lung seen by these physicians in roughly 12 preceding months. Sixty-five cards were returned of which 36 responded that they had seen no cases at all compatible with farmer's lung. The other 29 respondents reported a total of 58 patients with evidence for acute farmer's lung and 56 with possible chronic or recurrent disease. Of course, no meaningful conclusion can be drawn with the possible exception that perhaps physicians need to consider the diagnosis more often.

Progressive restrictive impairment, hypoxia, and decreased lung compliance with eventual shrinkage of the upper lobes and cor pulmonale have been seen in patients with recurrent attacks of farmer's lung. No good data are available on the frequency of this chronic form, and it is an

About the Institute of Agricultural Medicine

The following are brief summaries of certain activities of the Institute of Agricultural Medicine. They indicate resource persons who may be contacted by Iowa physicians for any needed consultation or assistance.

I. TOXICOLOGY—PESTICIDES

The facilities of the Toxicology Section of the Institute of Agricultural Medicine are available to Iowa physicians needing information on the toxic properties of various chemicals, particularly pesticides. The section has a decade of experience in study of pesticide effects on man. A substantial part of recent world literature resources are available at the Institute. Laboratory services provide the means for determining whether any of a broad spectrum of pesticides (now including many herbicides and some fungicides) have been absorbed by handlers or applicators. It is the mission of the toxicology section to assist physicians in detecting, managing, and preventing poisonings caused by farm chemicals. There is no charge for consultation or for chemical analyses done to determine whether personal absorption of pesticide has occurred in farmers or other handlers.

Many Iowa hospitals have been provided by us with a listing of potentially dangerous pesticides used in Iowa. In addition, Donald P. Morgan, M.D., has prepared a manual of emergency care in cases of pesticide poisonings, which is being published by the Environmental Protection Administration. When the copies become available, they will be distributed to any Iowa physician who desires one.

The Toxicology Section would appreciate knowing of injuries or poisonings possibly or definitely caused by pesticides, whether the services of the Institute are required or not. Contact either Donald P. Morgan, M.D., Ph.D., or Victor B. Beat, D.V.M., at 319-353-5558, if you have inquiries or messages.

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area that needs to be investigated actively. Certainly from an economic as well as personal point of view, the development of such a condition can be catastrophic for the farmer and his family. Better definition of the natural history of the disease, including an improved reporting system, might be the prelude to adequate compensation for the farmers whose productive years are cut short because of pulmonary disability.

Treatment of farmer's lung involves removal of offending antigen and provision of supportive measures. Steroids are used only in severe cases and antibiotics are unnecessary except in cases of documented superinfection.

The main attempts should be aimed at prevention, with the education of both farmer and physician playing an important role. Most measures aim at altering conditions which are favorable for mold growth and spore formation and/or attempts to keep farmer and antigen as far apart as possible. Some measures include the following:

1. proper drying
2. proper ventilation of storage and transfer areas
3. mechanized systems for storing and transferring materials
4. masks
5. special treatment of organic material to inhibit actinomycetes growth (1% propionic acid treatment for example)
6. wetting down of material prior to working with it to cut down on dust
7. changed occupations

The first three measures are in widespread use now, not so much to prevent farmer's lung but because they represent methods of improved productivity on the farm. Measures 4-6 are infrequently employed, and the last measure, though drastic, is sometimes forced upon the most unfortunate sufferers.

A distinctly different problem involving the respiratory system is silo-filler's disease which is entirely preventable. Sudden death in agricultural workers exposed to fumes from recently

II. COMPARATIVE MEDICINE

One of the principal objectives of the Comparative Medicine Section of the Institute of Agricultural Medicine is to identify relationships between health in man and health in animals. The primary types of relationships of animals and man that the Comparative Medicine Section is interested in include: 1) infectious diseases transmissible from animals to man (zoonoses); 2) animals as models of human disease; and 3) non-infectious diseases contracted as a result of working with livestock.

A physician may call regarding any case over which he has questions. Telephone consultation is available, and field investigation will be carried out by members of the Institute when it is warranted. The areas of interest include infectious as well as non-infectious diseases that may be related to animal contact. Of particular interest at this time are possible relationships of bovine and human leukemia, and health problems associated with raising swine in confinement.

For questions or consultation, please contact Kelley J. Donham, M.D., D.V.M., at the Institute of Agricultural Medicine, 319-353-4872. In order to more effectively develop research programs, the Comparative Medicine Section would appreciate knowing of any problems, regardless of whether consultation or other services are requested.

III. FARM ACCIDENT PREVENTION

The Accident Prevention Section of the Institute of Agricultural Medicine has been actively involved in the study of farm accidents since 1959. This has involved studies on farm tractor overturn, power take-off injuries, farm family accident studies (accident investigation), rotary power lawn mower injuries, corn picker accidents, flammable fabric burns, anhydrous ammonia injuries, power tool injuries, chain saw accidents, and snowmobile accidents among others. As a result of Institute findings, in many instances design changes and shielding devices have been instituted by industry.

For any questions or consultations, please contact L. W. Knapp, Jr., Director, Section of Accident Prevention, Institute of Agricultural Medicine at 319-353-4872.

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filled silos has been recognized for many years with the first reports appearing in 1914.[10] It was not until 1949,[11] however, that nitrogen dioxide was suggested as the culprit, and not until 1956 that a set of relatively simple experiments proved the concentration of this yellow gas correlated nicely with the development of the signs and symptoms of silo-filler's disease.[12] Simple asphyxiation also causes silo deaths but true silo-filler's disease is on the basis of lung damage specifically caused by nitrogen dioxide.

It is normal to find some nitrates in all growing plants and in the formation of silage. Low levels of nitrogen dioxides are probably always produced. They may reach critical levels under any one or more of the following conditions:

1. high nitrate soils, natural or fertilizer induced
2. drought, particularly in the early part of the growing season
3. long periods of ultraviolet or visible light exposure which favors assimilation of nitrates by plants

The mechanism of injury to the being by nitrogen oxides is on the basis of their powerful oxidizing ability.[13] There is pulmonary edema, inflammatory cell influx, bronchoconstriction, alveolar duct dilatation and alveolar epithelial and capillary endothelial injury. Although some nitrogen oxides will be measureable as long as one year after silo filling, the dangerously high levels last only about two weeks. Corn silage is the most common type implicated.

Compared to farmer's lung, silo-filler's is rare but the high case fatality rate and the fact that it is entirely preventable give it continuing importance.

Preventive measures include the following:

1. keep out of silos during the two week danger period
2. close all doors before putting in silage
3. go up outside ladder to level off silage
4. remove doors down to silage if silo is not completely full
5. check fresh silage on steps in chute; stains indicate presence of NO_2. If unstained for two days, concentration is probably not dangerously high.
6. effect entry in silo only with complete O_2 support system
7. ventilate by opening cover flap and blowing for 24-48 hours before entering

PROBLEMS DUE TO ANIMAL CONTACT

The farmer's contact with his animals has allowed him to fall prey to a number of disorders. This section will touch on four such disorders.

Zoonotic Diseases

The term "zoonoses" has been used rather loosely from time to time in the discussion of infectious diseases that involve both man and animals. More correctly, there are four types of relationships that exist in terms of disease transmission between man and animals:

1. diseases of vertebrate animals transmissible to man and other animals (zoonoses)
2. diseases of man transmissible to other animals
3. diseases of vertebrate animals chiefly transmissible to man
4. diseases transmissible to man from environment (animals being the source of environmental contamination)

These relationships are important not only because the farmer is frequently involved with livestock but also because the agricultural work place

TABLE I

THE OCCUPATIONAL SIGNIFICANCE TO AGRICULTURAL WORKERS OF SELECTED DISEASES COMMON TO ANIMALS AND MAN: RISK FOR AGRICULTURAL WORKERS IN COMPARISON TO THE GENERAL RURAL AND GENERAL URBAN POPULATION

Definite Risk	*Questionable Risk*	*Doubtful Risk*
1. Brucellosis	1. Pseudotuberculosis	1. Cowpox
2. Leptospirosis	2. Psittacosis/ornithosis	2. Taeniasis
3. Toxoplasmosis	3. Vibriosis	3. Dermatophilosis
4. Rabies	4. Salmonellosis	4. Trichinosis
5. Tetanus	5. Listeriosis	5. Pneumococcal infections
6. Anthrax	6. Tuberculosis	6. Babesiosis
7. Erysipeloid	7. Streptococcal infections (pharyngitis, erysipelas)	7. Fascioliasis
8. Q Fever	8. Influenza and parainfluenza	8. Giardiasis
9. Histoplasmosis	9. Plague	
10. Blastomycosis	10. Cryptococcosus	
11. Ringworm	11. Nematodiasis (cutaneous larval migrans, visceral larval migrans and strongyloidiases	
12. Equine encephalitis	12. Colorado tick fever	
13. Newcastle disease	13. Pneumococcal infections	
14. Pseudocowpox	14. Encephalomyocarditis	
15. Vesicular stomatitis	15. Dirofilariasis	
16. Contagious ecthyma		
17. Staphlococcal infections		
18. Echinococcosis		
19. Collibacillosis		
20. Tularemia		
21. Acariasis		
22. Pasteurellosis		
23. Rocky Mountain spotted fever		
24. Sporotrichosis		
25. Balantidiasis		

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frequently encroaches on the ecological niche of many feral animals and that of domestic non-livestock species.

Going back in search of meaningful data on the zoonoses from an occupational point of view, one again comes up empty handed. There are a number of excellent reviews on various entities, but most lack information concerning incidence, prevalence and exact relationship between the zoonotic disease and the agricultural occupation.

This problem was partially remedied in 1974 when Dr. Kelley Donham[2] took 49 diseases common to animal and man in the United States that were felt to have potential as occupational diseases of farmers. For each of the 49 diseases (selected from 170 diseases compiled by the CDC as occurring in man and animal) extensive literature review was carried out and an attempt was made to place each disease into one of three categories according to relative risks of agricultural workers as compared to general rural populations and general urban populations as follows:

1. diseases for which agricultural workers have *definite* risk
2. diseases for which agricultural workers have *questionable* risk
3. diseases for which agricultural workers have *doubtful* risk

The type of data considered on each of the 49 diseases included exposure potential for the agricultural worker, extent of animal reservoir, mechanisms of transmission, case reports, morbidity and mortality reports, isolation of etiologic agents, serological surveys and epidemiological studies.

The results of this survey are shown in Table I[2] and verify that 25 diseases have enough support in the literature to be classified as a definite risk to agricultural workers.

Antibiotic Resistance

For years investigators have theorized that antibiotic additives in animal feed might lead to the development of antimicrobial-resistant strains of bacteria in man.

This thesis was supported by the studies in Japan in the late 1950's in which it became apparent that antibiotic resistance of bacteria in some cases was determined by genes present in episomal DNA (Resistance factors) and that these could be transferred from one bacterium to another during conjugation activities (Resistance Transfer Factor-RTF). These forms obviously thrived at the expense of RTF-negative bacteria in a milieu of antibiotics.

A January 18, 1975 communication in *The Lancet* revealed that animal food examined by Howells and Joynson contained significant numbers of antibiotic-resistant coliforms and that many of these are capable (by mechanisms mentioned previously) of transferring this resistance to other organisms. In several studies both in the United States and the United Kingdom, an increased incidence of resistant strains of intestinal coliforms was found in individuals in contact with animals receiving antibiotics as growth supplements.

Closer to home, an Iowa study involved 148 families made up of 649 people studied with regard to antibiotic resistance of *E. coli* and *Klebsiella*.[14] Part of the results of that study showed that *E. coli* isolated from members of farm families with animals had a significantly higher rate of resistance to four or more antibodies (15%) than *E. coli* isolated from rural families without animals (9%) or urban dwellers (5%). The exception to this trend, however, occurred when a family member had been hospitalized in past months. Under those circumstances there tended to be no difference between rural people with animals and those without.

The implications here, of course, are potentially devastating, and the final impact may not be felt for a number of years yet, but it must be realized that those methods which are employed to select resistant organisms in the laboratory and even in the hospital are in full swing in the barnyards of Iowa.

Leukemia

In several studies rural populations in the United States have been shown to have slightly increased standardized mortality ratios (SMR) for leukemia. One such study[15] contained an analysis of the death rates from all causes, all cancers, leukemia, and lymphoma in California farm and nonfarm residents between 1959 and 1961. The main findings were:

1. total mortality was similar in farm and nonfarm residents
2. mortality from all cancer was significantly reduced in farm residents
3. leukemia mortality was *not* reduced in farmers. Both male and female residents had SMR's of 114, compared with 99 and 100 for male and female nonfarm residents
4. there is preliminary evidence that the same thing may hold for multiple myeloma and lymphoma

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Although much current evidence fails to support the idea that cancer may spread between animals and man, one possible explanation for the findings in the California study assumed some credibility when it was shown that infant chimpanzees fed from birth on unpasteurized milk from cows naturally infected with bovine C-type virus developed acute leukemia with accompanying *Pneumocystis carini pneumonia.*[16] Another report[17] revealed that between 1970 and 1973, seven cases of *acute non-lymphocytic leukemia* were diagnosed in the village of Elmwood, Wisconsin and surrounding area. This was more than a twenty-fold increase in number expected. It was postulated that the cluster of cases might bear a relationship to bovine leukemia since the town was located in dairy farming country and because a number of the patients had either worked at or lived near the town creamery.

There is some evidence to suggest that Iowa lies in a "leukemia belt." Currently, a number of investigators are looking into reasons for an apparent increase in the incidence of chronic lymphocytic leukemia and lymphomas in midwest farmers. The viral theory for the increase is only one of several theories under consideration.

Confinement

With the advent of the confinement unit concept, today's specialized farmer is able to handle a large number of a single species in concentrated areas, thereby exposing himself and his fellow workers to the common environment of that species for a larger period of time and creating yet another health hazard for the agricultural worker.

Many of the units in use today have slotted floors over manure pits. The usual result is a manure slurry which is frequently allowed to accumulate for weeks or months. This concentration of animal and manure results in potentially excessive direct human contact with pathogenic microorganisms and with harmful gases released from the slurry. Even though ventilation systems are employed to reduce moisture, remove odors and to circulate fresher air, dust particles and microorganisms tend to accumulate in the air of the confinement unit in rather high concentration.

Until recently very little effort had been made in the United States to document human cases of infections or toxic diseases in confinement unit workers. European literature, on the other hand, presented some evidence that both infectious and toxic processes were prominent and that workers who already had respiratory tract deficits (e.g., smokers, atopic individuals, etc.) tended to have more trouble than normal workers, even though the latter also showed diminished work capacity due to particularly concentrated atmospheres of gases, dust, dander and spores.

Stanley Diesch and his co-workers in Minnesota looked particularly at the potential for spread of two microorganisms in the confinement unit, namely leptospires and salmonella. They found leptospires may survive as long as 138 days at summer temperatures in aerated beef cattle manure slurry and salmonella for 47 days at winter temperatures.

Intuitively, there are both acute and chronic health hazards due to the potentially high levels of gases such as H_2S and NH_3. Though documented human fatalities are hard to find in the literature, evidence for the existence of such hazards is supported by acute deaths and chronic conditions in both swine and cattle.

From the Iowa point of view, a study of confinement units is in progress at the State University of Iowa Institute of Agricultural Medicine in which some of the acute and chronic effects of the confinement unit will be explored. In addition, studies in the proper disposal of the manure slurry will have to be undertaken, especially in view of the potentially long survival times of the microorganisms and because many of these microorganisms may be antibiotic resistant through mechanisms described above.

CONCLUSION

Perhaps the belief that farmers represent one of the healthiest occupational groups is not true. Certainly, in large measure, their problems have not been well studied before the present time. It is hoped that the foregoing material and that which follows in the addenda will help the Iowa physician become more cognizant of the occupational diseases associated with agriculture and will aid him in diagnosing and treating these problems.

REFERENCES

The references contained in this article may be obtained either from the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

Memorial Thoughts

C. E. RADCLIFFE, M.D.— A GREAT PERSON

The State of Iowa, the University and its College of Medicine, and the Iowa Medical Society lost a great citizen September 8, 1976. For years he practiced medicine at the research level, and taught medical students and doctors tirelessly. He served on many medical college committees. He was chairman of the Board of Iowa Medical Service (Blue Shield) after years of service on the Board. He was active in the Iowa Medical Society. He was first alternate delegate and then delegate from Iowa to the American Medical Association. He was a devoted family man. Through all of his positions he maintained a good sense of humor and a ready wit. Illness forced him to cut back his activities during the last one and a half years of his life, so that he did less practice, less teaching, less traveling to teach and attend meetings, much to his dislike, but he did not complain. In fact, he proudly showed us a birthday card several months ago from one of his daughters which said, "Congratulations on a year of good clean living—better luck next year!"

Chris—*or Rad as many called him*—was a great person. I'll miss him—and so will a great many others who knew him.—L. W. Swanson, M.D., Mason City, President-elect, Iowa Medical Society

THE PASSING OF A LEGEND

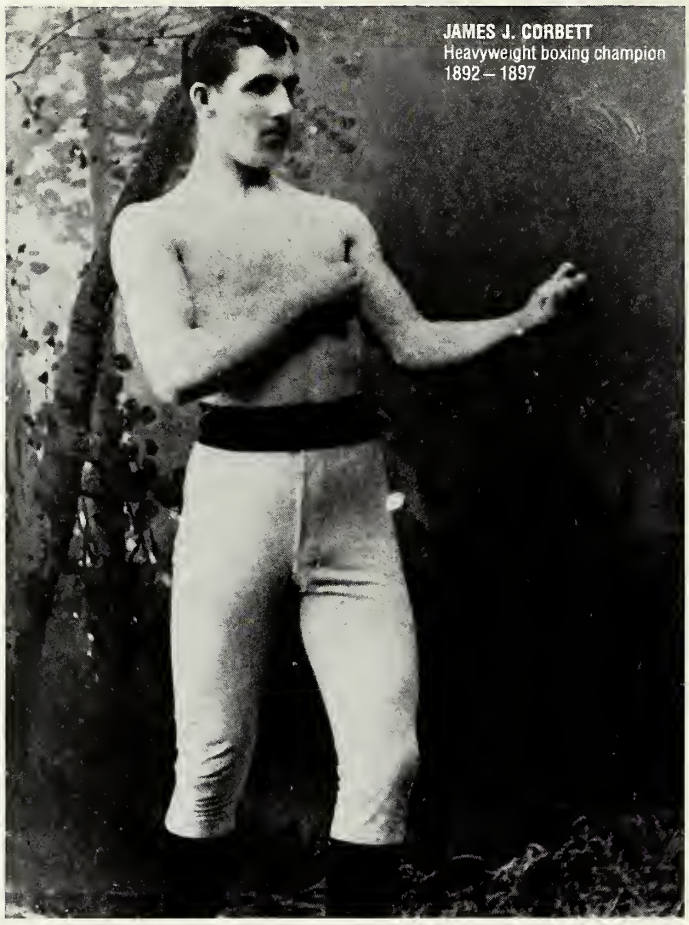
When one is asked to offer a tribute to an outstanding colleague and friend, I'm sure it is necessary and proper to list his many accomplishments. C. E. Radcliffe, M.D., has been an inspirational force in the medical society for many years. He was Johnson County president, district judicial councilor (serving as secretary and president for some time), alternate delegate, and then delegate to the AMA, and long time member of the Executive Council. This is not to omit his many offices in the state and national dermatological societies.

I feel more comfortable remembering the things that "lists" do not tell us. Rad's superb ability as a scholar, innovator, teacher, and friend to all who touched him. Who can forget the impish grin under the jaunty English cap covering the sparsely covered head on the man who was a pioneer in the hair transplant field (his comment being "I can't afford one")?

Remember the witty reports to the Executive Council about AMA meetings, the famous one-liners—"the suggestion was met with a deafening silence," or "the motion was considered with enthusiasm bordering on coma"—his quips on the floor of the House and running repartee with the Speaker? He had the record of never having made a nominating speech for a losing candidate, including the famous one for a candidate for vice speaker: "Anyone within earshot knows he is a speaker and the vice speaks for itself."

In Rad's last few years he became interested in C.B. radio and exchanged conversation, stories, and witticisms with all. In their jargon—10-4 Old Buddy—we loved you.—L. D. Caraway, M.D., Amana, Speaker, IMS House of Delegates

Famous Fighters



NEOSPORIN® Ointment
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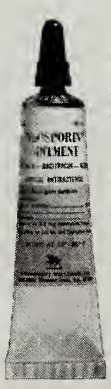
Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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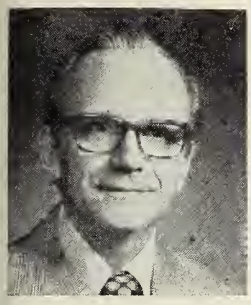

Editorials

M. E. ALBERTS, M.D., Scientific Editor

FORENSIC PATHOLOGY

An interesting commentary* about the endeavors of the forensic pathologist is presented by James L. Luke, M.D., in the July 1, 1976 issue of THE NEW ENGLAND JOURNAL OF MEDICINE. His is a message from what might be a crowded office piled high with books and reports. He makes a plea to the rest of the medical world to understand the role of this specialty. It is intended "not simply to determine the cause of sudden death, but more importantly to understand the particular circumstances of what happened." There is a daily challenge to unravel the vagaries of fate and to determine the truth by means of experience and judgment.

In 1968 recommendations were made to remedy a severe national shortage of forensic pathologists. These have not been implemented. The majority of the United States population continues to be unprotected by sound medicolegal systems. The forensic pathologist is involved not only with questions of foul play, possible murder-vs-suicide, or other criminal causes of death. He is concerned with the epidemiology of narcotics fatalities, various aspects of child abuse and safety, as well as a host of other public health and safety considerations. Luke mentions gun control and alcoholism, as well as the safety of industrial products. If a law school teaches the lawyer to know law but very little about scientific investigation, and physicians learn to heal, there must be a common ground for the victim to be spared miscarriage of justice. A word repeated a number of times in the article is "reality." The forensic pathologist faces reality in his labors. Man is not immortal and invulnerable. Fact must be separated from fancy. Truth must be evolved from the entire process. As the author emphasizes, death must be examined within the context of life, and the victim in terms of his community. This is a valid message. Perhaps just one of my readers will heed the call to enter this exciting field.—M.E.A.

THE YOUNG AND THE OLD

These comments are directed primarily to those physicians who graduated from medical school in the late 1940's. Of course, the more recent graduates may consider these points with us, but for now I beg they listen, and later perhaps we can hear what they have to say. My colleagues of the 1940 vintage: Are you spending as much time in the hospital with critical patients as you did 20 years ago? Has your practice become more oriented toward the mundane tasks of office medicine? Do some of the new laboratory procedures and results seem bewildering? Do the computer-controlled mechanical appliances confuse you? Do you prefer your "own way" of treating an acute medical emergency?

I was fascinated with a discussion† recently published by Howard B. Spiro, M.D., and Harvey N. Mandell, M.D., physicians from the Yale University School of Medicine. Being of the age group to whom this discussion is directed, it led to some real soul-searching. I am sure many of you have noticed the most exciting phases of medicine (acute coronary care, intensive-care neonatology, transplant-surgery) are being accomplished for the most part by young physicians. Also, the nurses in the intensive-care centers are

* Luke, J. L.: Forensic pathology, New Eng. J. Med. 295:32-34, 1976.

† Spiro, H. M. and Mandell, H. N.: Leaders and the swan—who should do family practice? New Eng. J. Med. 295:90-92, 1976.

free of wrinkles and gray hair. The talents of older physicians are applied to the art of triage, emotional care, perhaps some screening tests, and gentle attention. After all, many patient complaints do resolve themselves, and every patient does not require a battery of laboratory studies, including various exotic determinations.

There has been much discussion about requiring young, newly-trained physicians to spend a year or two in a rural area to relieve the "physician shortage." Can you imagine all that new technology in such a setting? That young physician should be based in a hospital caring for the acutely ill person, gaining maturity along with his experience. Perhaps the older physician could spend a one- or two-year sabbatical in an undoctored area where experience and judgment are more important than technology. Uprooting his home and his social and business surroundings would be a burden, but the government could care less about that. Maybe as an incentive the income during that period of time could be tax-free. Furthermore, the change from the hectic city life might induce the older physician to stay in the rural area or the beautiful mountain valley. —M.E.A.

DIABETES CONFERENCE

Current concepts in the treatment of diabetes mellitus will be covered at a December 1 meeting at the Area XI Community College in Ankeny, Iowa. The symposium is sponsored by the American Diabetes Association (Iowa Affiliate), the University of Iowa College of Medicine, the Iowa Academy of Family Practice, The Iowa Dietetic Association and the Iowa Nurses' Association.

Speakers will include Donnell Etzwiler, M.D., President of the American Diabetes Association, and Director, Diabetes Education Center, Minneapolis; Charles Kilo, M.D., Assistant Professor of Medicine, Washington University School of Medicine; and David L. Horowitz, M.D., Assistant Professor of Medicine (Endocrinology), University of Chicago.

The program has been accepted for credit from various accrediting organizations. A $15 registration fee will cover the lunch and other expenses. For further information or registration forms, please contact the American Diabetes Association, Iowa Affiliate, c/o Iowa Lutheran Hospital, Penn at University, Des Moines, Iowa 50316.

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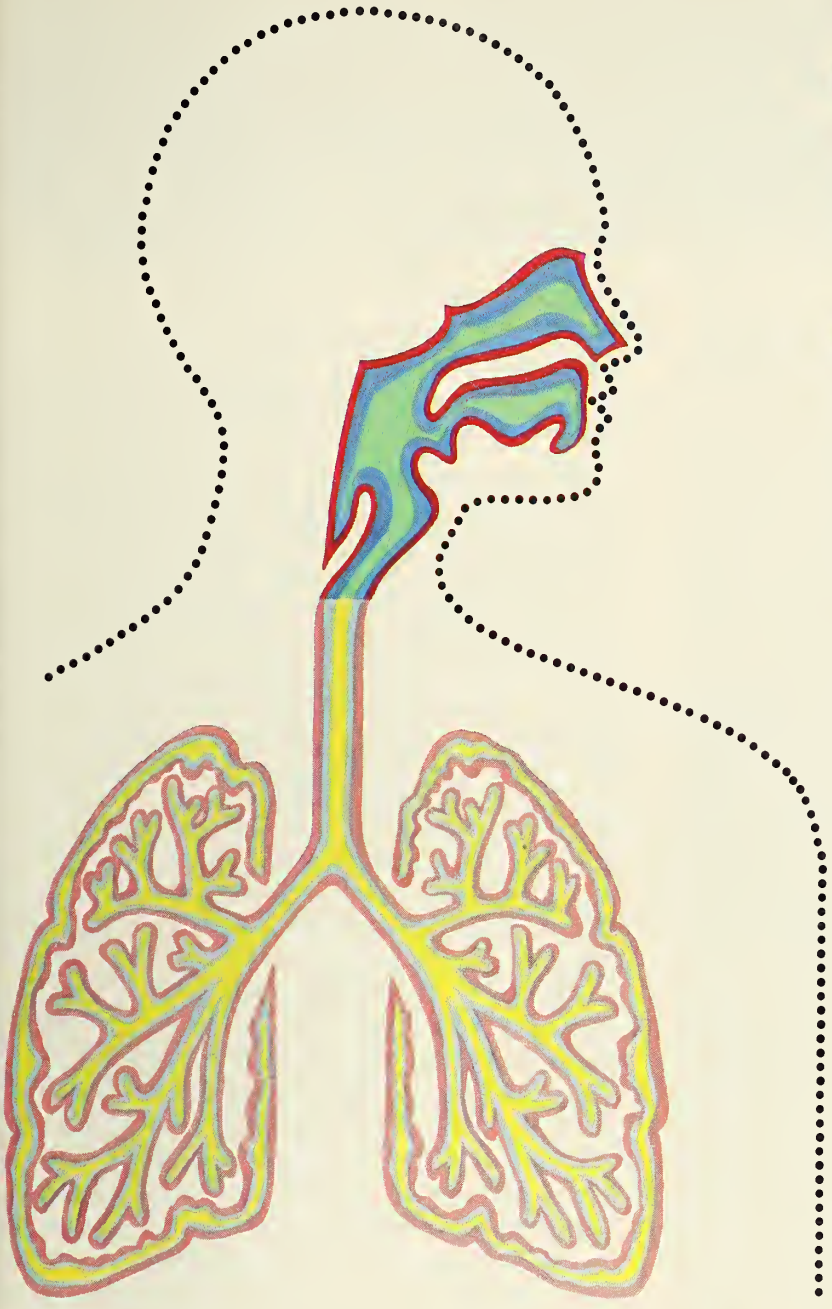

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ADVERSE REACTIONS: Drowsiness and dryness of the mouth are occasionally associated with antihistamine therapy in some individuals.

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ADVERSE REACTIONS: Drowsiness and dryness of the mouth are occasionally associated with antihistamine therapy in some individuals.

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The above represents a brief summary. See package inserts for full prescribing information.

VOTE ELECTION DAY—TUESDAY, NOVEMBER 2

THE ELECTION of 126 members of the Iowa General Assembly will occur Tuesday, November 2. In addition, six Iowans will be chosen to serve in the U. S. House of Representatives for the next two years.

For sure, these legislative contests are receiving far less media visibility than the presidential/-vice-presidential race. But, on the other hand, in terms of voter attention, they may stand to benefit from the absence of elections to the major state administrative or executive offices.

Regardless, the selection of these Iowans to serve in the federal and state lawmaking roles is crucial to all citizens, including most certainly physicians and their families. Over the next two years various important health care issues will be in the legislative spotlight, e.g., professional liability, certificate of need, family practice, etc.

Our October pre-election admonition to all who serve in the health care field is double-barreled and quite obvious: (1) Learn all you can about the thinking (particularly as it relates to social, health care and fiscal issues) of the candidates for whom you have the opportunity to vote, and (2) Be certain to vote on November 2 for the nominee whose philosophy most closely aligns with yours.

Obviously, the successful candidate must have the impetus to attract voters and this impetus must be provided by campaign supporters and workers. While the time to become newly associated with a particular candidate will be exceedingly short when this is read, this is still a possibility which needs to be considered. Its importance cannot be stressed too heavily.

The Iowa contests for the U. S. House of Representatives have incumbents pitted against challengers in all instances. The incumbent is listed first in the review of major party candidates below:

1st District—Edward Mezvinsky (D), Iowa City vs. James A. S. Leach (R), Davenport

2nd District—Michael Blouin (D), Dubuque vs. Tom Riley (R), Cedar Rapids

3rd District—Charles E. Grassley (R), New Hartford vs. Stephen J. Rapp (D), Waterloo

4th District—Neal Smith (D), Altoona vs. Charles E. Minor (R), Des Moines

5th District—Tom Harken (D), Ames vs. Kenneth R. Fulk (R), Clarinda

6th District—Berkley Bedell (D), Spirit Lake vs. Joanne D. Soper (R), Sioux City.

The 126 seats to be filled in the Iowa General Assembly represent the full House of Representatives and a portion of the Senate.

Of the 100 desks open in the House, 87 are held by incumbents who are seeking additional terms. There are 55 Democrat incumbents up for re-election and 32 Republicans in similar capacities. This means 13 seats are being sought by non-incumbent opponents. In various instances, several of the Representative candidates have served previously in the lower chamber but are not now in office.

There are 19 incumbents up for re-election in the Iowa Senate. The party distribution here is nine Democrats and 10 Republicans. Seven Senate seats are being sought by individuals who have had previous experience as state legislators. It is the even-numbered senatorial districts which are under contest this year except for one special odd-numbered race caused by a resignation.

The right to free elections and the participation in them is something to which a lot of lip service is given. Then election day rolls around, and even with a presidential contest, the agonizing statistic is likely to emerge that only 50 or 60 per cent of the electorate made it to the polls. This is indeed a disheartening commentary on our open and representative form of government.

The plea is a familiar one. The vote is a precious instrument. Use it thoughtfully and at every opportunity. *Remember—Tuesday, November 2, 1976—VOTE!*

IN THE PUBLIC INTEREST

Medical Assistants

by BETTY EHLERT, CMA-A

OCTOBER—20TH ANNIVERSARY OF AAMA

The first and only national professional organization exclusively for medical assistants was born October 28, 1956, in Milwaukee, Wisconsin. Representatives from 11 state organizations, including Iowa, ratified the constitution, approved the by-laws, and elected officers for the American Association of Medical Assistants. Membership is now over 17,000. The organization has existed to foster improvement in the medical assistant's performance, thus EDUCATION is the by-word for the national association.

THE EDUCATION STORY

The AAMA Certification Board was established in 1961 with a pilot examination given at the 1962 national convention in Detroit. That same year, Merck, Sharp and Dohme began a grant program towards certification efforts and has continued to award an annual grant for the advancement of education.

The first certification examination was given in 1963 to 112 medical assistants with only 24 earning certificates. In 1964 the number qualifying as CMAs increased to 37 and the CMA pin became available in 1965. Forty-nine assistants achieved certification that year, 62 in 1966, 74 in 1967, and 64 in 1968. A certification loan fund was established in 1969 to provide financial assistance to those needing such aid to meet examination fees, and 96 certificates were issued that year. A mini-test developed in 1969 gave encouragement towards certification and was first given at the annual meeting in Hawaii. Ninety-two CMA certificates were issued in 1970, 169 in 1971, and 304 in 1972. In 1973, a record of 1,000 plus applications were received, with a total of 356 candidates passing.

Because the medical assistant performs a variety of duties, the certification exam was broadened in 1974 to encompass both administrative and clinical subject matter, and the Board established a policy that the term "Certified Medical Assistant" applied to a person who was skilled in the basic procedures fundamental to all medical offices and the medical assisting profession. Although an individual medical assistant's primary responsibility could be in either an administrative or clinical area, the term "CMA" should designate one capable of performing in either area when necessary.

Recognizing the need for specialization and a desire on the part of many assistants to demonstrate competency in a particular aspect of their profession, the Board began offering three specialty examinations, measuring the candidates' expertise in either administrative, clinical, or pediatric specialties. A total of 541 certificates were awarded in 1974, and 2,373 applications were received for the 1975 exam, with 1,338 passing. The trend is definitely continuing with over 3,000 taking the basic and specialty examinations this year.

IOWA STRESSES EDUCATION

There is time, money, personal sacrifice and a lot of studying involved in attaining certification and Iowa is one of the leading states for number of certified medical assistants, right up front with California and Texas. Iowa medical assistants are proud of their progress and will proudly observe the AAMA's 20th anniversary during October.

About IOWA Physicians

Dr. Michael L. Deters joined the staff at Internal Medical Associates in Waterloo in August. A native of Waukon, Dr. Deters received the M.D. degree at U. of I. College of Medicine and completed his residency in internal medicine at University of Michigan. . . . **Dr. Robert C. Miller,** Waterloo physician for 27 years, has joined the Student Health Department staff at University of Northern Iowa in Cedar Falls. . . . **Dr. Fred R. Schultz** began a family practice in Rock Rapids in August. Dr. Schultz received the M.D. degree at U. of I. College of Medicine and completed postgraduate work in pediatrics at Johns Hopkins Hospital in Baltimore, Maryland. . . . **Dr. Steven Palmer** has joined his father, **Dr. H. C. Palmer,** in family practice in West Liberty. Dr. Steven Palmer received the M.D. degree at U. of I. College of Medicine and completed two years of family practice residency at Iowa Lutheran Hospital in Des Moines. Dr. H. C. Palmer, also a graduate of U. of I. College of Medicine, has practiced in West Liberty for 23 years. . . . **Dr. Terrence L. Briggs** is new associate of **Drs. Philip McFadden** and **Daryll M. Eggers** in the practice of obstetrics and gynecology in Marshalltown. A native of Cedar Rapids, Dr. Briggs received the M.D. degree and served his residency at U. of I. College of Medicine. He has just completed two years in U. S. Air Force at Andrews AFB, Washington, D. C.

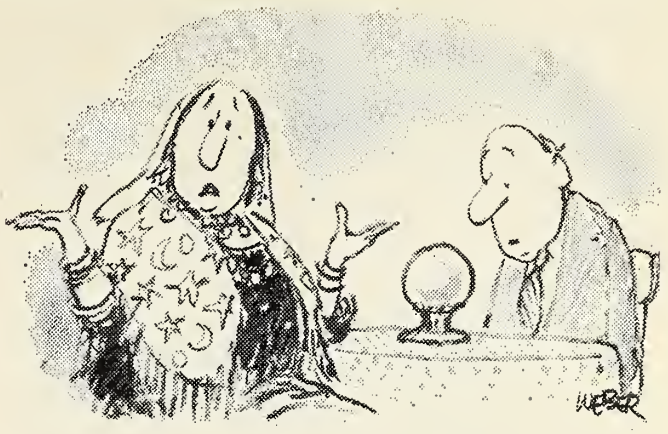
Dr. Maurice W. Van Allen, professor and head of the Department of Neurology at U. of I. College of Medicine, is new chief editor of the AMA's *Archives of Neurology.* Earlier this year, **Dr. Frederick C. Blodi,** professor and head of the Department of Ophthalmology at U. of I. College of Medicine, became chief editor of the AMA's *Archives of Ophthalmology.* . . . **Dr. R. J. Moeller** has joined **Dr. Gene M. Kuehn** in the practice of obstetrics and gynecology at Mason City. Dr. Moeller received the M.D. degree at U. of I. College of Medicine; served his internship and residency at Indiana University Medical Center in Indianapolis, Indiana. . . . **Dr. Randolfo DeLeon** has joined **Dr. Robert C. Thompson** at the Family Practice Center in Eldora. A native of Guatemala, Dr. DeLeon graduated from medical school in that country in 1966. He then served a rotating internship and surgery residency in this country, later returning to Guatemala. When his home and practice were victims of the February earthquake, Dr. DeLeon contacted a former classmate in Mason City and learned Dr. Thompson was seeking an associate. . . . **Dr. Subhash Sahai** has joined the staff at Medical Associates in Webster City. Dr. Sahai received the M.D. degree at U. of I. College of Medicine and served family practice residency at Broadlawns Hospital in Des Moines. His wife, **Dr. Sushma Sahai,** completed her medical training at New Delhi University in India and is presently in pediatric residency at Raymond Blank Memorial Hospital for Children in Des Moines. Following completion of her residency, Dr. Sushma will join her husband at Medical Associates.

Dr. Tom L. Pester joined Bluffs Surgical Associates in Council Bluffs in July. Dr. Pester received the M.D. degree and served his residency in surgery at University of Nebraska College of Medicine. . . . **Dr. C. E. Lierman,** Lake View, was recently honored at an open house for his 30 years in medical practice in that community. . . . **Dr. Alfonso Torres** has joined the staff at the Bluff Medical Center in Clinton. Dr. Torres received the M.D. degree at National University of Mexico in Mexico City and took postgraduate work at Children's Hospital Medical Center in Boston, Massachusetts; District of Columbia General Hospital in Washington, D. C.; and Georgetown University where he recently completed his training in the field of pediatric nephrology. . . . **Dr. Gary L. Richardson** has joined **Dr. C. L. Kelly, Jr.** in the practice of surgery in Charles City. Dr. Richardson received the M.D. degree and served his residency in surgery at U. of I. College of Medi-

cine. . . . **Dr. Michael R. Mickelson** has been appointed assistant professor of orthopedic surgery at U. of I. College of Medicine. Dr. Mickelson received the M.D. degree at U. of I.; interned at Highland General Hospital in Oakland, California, and completed his orthopedic residency at University Hospitals in Iowa City. . . . **Dr. T. A. Robertson,** West Liberty, retired from active practice in August. A graduate of U. of I. College of Medicine, Dr. Robertson has served the medical needs of West Liberty citizens since 1937.

Dr. Daniel B. Eggers joined the staff at Rohlf Memorial Clinic in Waverly on August 1. Dr. Eggers, a native of State Center, received the M.D. degree at U. of I. College of Medicine and completed his residency in Family Practice at San Bernardino County General Hospital in California. . . . **Dr. Robert P. From,** West Des Moines, was a program participant in a recent coronary care seminar at Creighton University School of Medicine in Omaha. . . . **Dr. Addison Brown, Jr.,** Mason City, was guest speaker at August meeting of Wright County Medical Society. Dr. Brown spoke on new developments in ophthalmology. . . . **Dr. Pa-yuan Wang** will begin medical practice at Dysart Clinic October 1. Dr. Wang received his medical training in Taiwan; interned at St. Elizabeth's Hospital in Chicago; served pathology residency at Christ Hospital in Oak Lawn, Illinois; and internal medicine residency at Ravenswood Hospital in Chicago, Illinois. . . . **Dr. John McKeown** has joined **Dr. David Wetrich** in the practice of obstetrics and gynecology at Ottumwa Medical Clinic. Dr. McKeown received the M.D. degree at U. of I. College of Medicine and served his residency at Colorado Medical Center in Denver, Colorado.

Dr. Albert L. Clemens, Des Moines, recently received his second AMA Physicians' Recognition Award. . . . **Dr. L. R. Fane,** Mason City, was guest speaker at Mitchell County ACLD meeting in St. Ansgar. Dr. Fane's topic was "The Physician's Role in Learning Disabilities." . . . **Dr. J. J. Straub,** Dubuque, was recently named "Boss of the Year" by the Chateau Chapter of the American Business Women's Association. . . . **Dr. Michael R. Mickelson** has been appointed assistant professor of orthopedic surgery at U. of I. College of Medicine. Dr. Michelson received the M.D. degree at U. of I.; interned at Highland General Hospital in Oakland, California; and completed his orthopedic residency at University Hospitals in Iowa City. . . . **Dr. David Siroospour** began general medicine and surgery practice in Keokuk October 1. Dr. Siroospour received the M.D. degree at Pahlavi University in Shiraz, India; interned at Bridgeport Hospital in Bridgeport, Connecticut; and served his residency in surgery at Bridgeport Hospital and VA Hospital in Des Moines.



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DEATHS

Dr. Christian E. Radcliffe, 59, professor and vice-chairman of Department of Dermatology at U. of I. College of Medicine, died September 8 at University Hospitals in Iowa City. Dr. Radcliffe received the M.D. degree and completed his residency in dermatology at U. of I. An active member of the Iowa Medical Society, he had served as chairman of many medical society committees and as an IMS delegate to the American Medical Association since 1964. He was a past president of Johnson County Medical Society; Iowa Dermatological Society; Iowa Health Council and University Athletic Club and was currently chairman of the Board of Directors of Blue Shield. He won awards from both the American Academy of Dermatology and American Medical Associa-

tion for his educational exhibits concerning dermatological problems.

Dr. C. W. Palmer, 94, Guttenberg, died August 3 at his home. Dr. Palmer received the M.D. degree at Chicago School of Medicine, Chicago, Illinois, and began his private practice of medicine in Guttenberg in 1923. He retired several years ago.

Dr. Dean M. Lierle, 81, distinguished medical educator and physician, died August 8 at University Hospitals in Iowa City. Dr. Lierle was professor and head of the Department of Otolaryngology and Maxillofacial Surgery at U. of I. from 1928-1965 and professor emeritus until his death. He was a former national president of several professional groups and author of numerous medical articles. In 1973 the Dean Lierle Surgical Center for outpatients, funded by gifts from Dr. Lierle's former students, was opened at University Hospitals.

Dr. Michael S. McCabe, 34, assistant professor of psychiatry at University Hospitals in Iowa City, died August 5 after the bicycle he was riding was struck by a car. Dr. McCabe received the M.D. degree at University of Kansas School of Medicine; served his internship at St. Luke's Hospital in Kansas City; and residency in psychiatry at Washington University in St. Louis, Missouri. He joined the U. of I. College of Medicine staff in 1974.

Dr. A. B. Carstensen, 86, longtime Linn Grove physician, died August 14 at an Indianapolis, Indiana hospital. Dr. Carstensen received the M.D. degree at U. of I. College of Medicine and interned at Cook County Hospital in Chicago. He began his Iowa practice of medicine in Jolley and later moved to Linn Grove. Dr. Carstensen was a life member of the Iowa Medical Society.

Dr. Oscar H. Banton, 91, longtime Charles City physician, died August 17 at a nursing home there. Dr. Banton received the M.D. degree at U. of I. College of Medicine in 1912 and interned at Washington Heights, New York. He played on one of the university's earliest football teams and donated the Oscar H. Banton Letterman's Lounge in the University Fieldhouse. A World War I veteran, Dr. Banton began the practice of medicine in Charles City in 1919. He was a charter member of the Lions Club and life member of the Iowa Medical Society.

Dr. James C. Taylor, 48, associate professor of pediatrics at U. of I. College of Medicine, died August 10 in Iowa City. Dr. Taylor received the M.D. degree at Columbia University; interned at New York's Bellevue Hospital and served his residency at Babies Hospital in New York. He joined the U. of I. College of Medicine faculty in 1961.

Dr. Bernard L. Trey, 84, Marshalltown, died at a local hospital on August 14. Dr. Trey received the M.D. degree at U. of I. College of Medicine and interned at Montreal General Hospital in Montreal, Canada. He began his practice of medicine in Marshalltown in 1919, retiring in 1972. He was a World War I veteran and life member of the Iowa Medical Society.

PHYSICIAN/PHARMACIST SERIES

A series of four continuing education programs for Iowa physicians and pharmacists will be presented in Iowa City, Waterloo, Mason City and Newton during a 10-day period in November. Entitled, "Clinical Pharmacy and Its Contributions to Improved Patient Treatment," the series is sponsored by The University of Iowa Colleges of Medicine and Pharmacy and the Iowa Chapter of the American Academy of Family Practice in cooperation with the Iowa Pharmaceutical Association.

Similar programs will be presented on the following schedule: Monday, November 8—Iowa City; Tuesday, November 9—Waterloo; Wednesday, November 17—Mason City; and Thursday, November 18—Newton. The topic, "Developing New Patterns of Practice for Improved Patient Care," will be discussed at each session by Reuben B. Widmer, M.D., associate professor, Department of Family Practice, and Dennis Helling, Pharm.D., R.Ph., assistant professor of clinical pharmacy, College of Pharmacy. In addition, an area physician and pharmacist will discuss the practical aspects of the subject at each location.

The program is approved for 2 hours credit by the AAFP and the AMA (Category I) and 0.2 Continuing Education Units. A brochure on the series is being mailed in October. It is hoped a similar project may be undertaken in the western portion of Iowa next spring.

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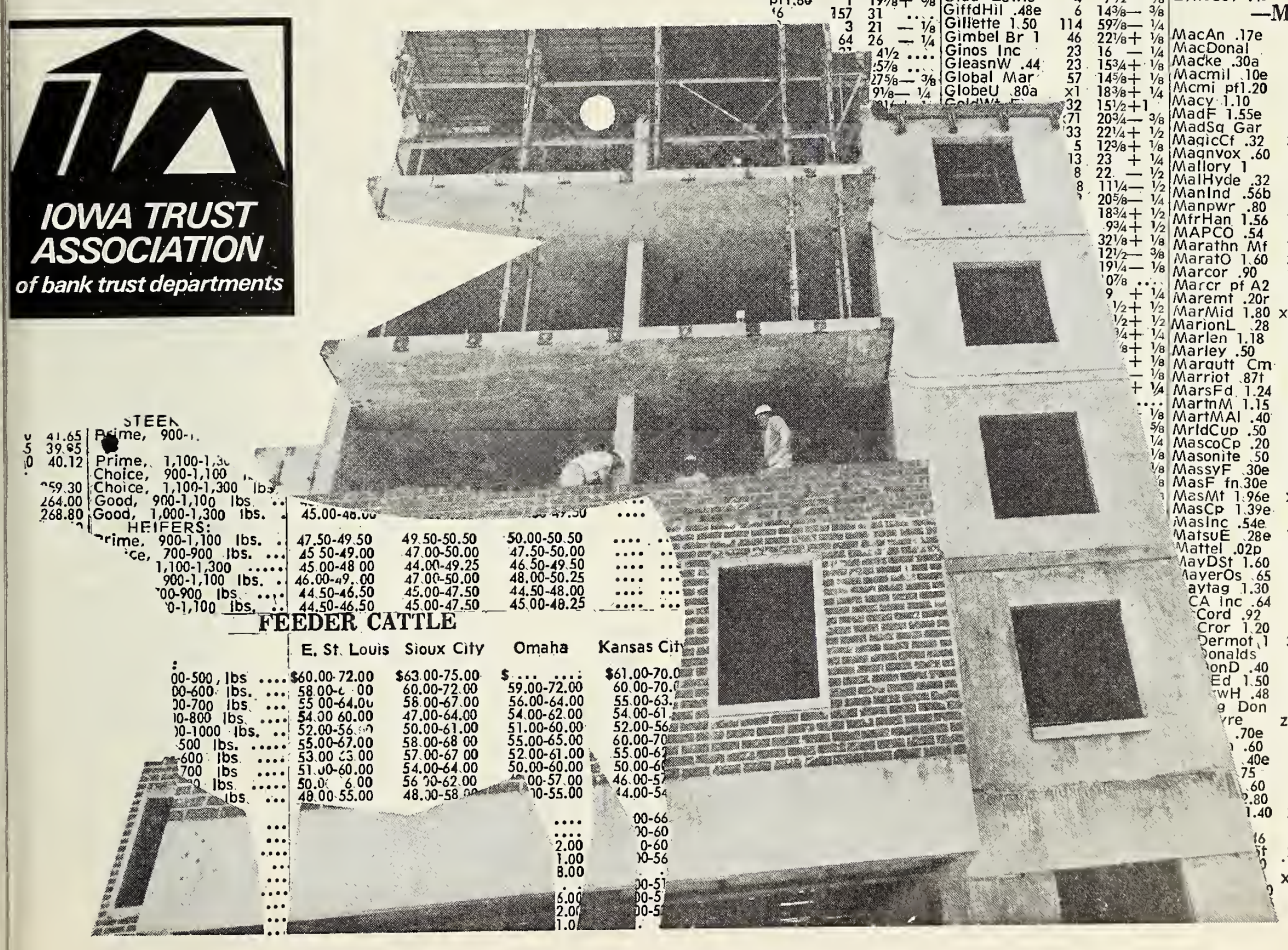

A Perspective on Medical Liability

MARK D. RAVREBY, M.D., J.D.
Des Moines

Physicians are engaged in continuing education to a much greater extent than lawyers and others. Even so, medical knowledge is advancing at such a pace keeping up is a great challenge. So says an Iowa physician/attorney who cautions that malpractice should not become the tail that wags the health care dog.

I RECENTLY ATTENDED a legal seminar. This attendance will count toward the required 15 hours of annual participation in approved post-graduate education activity. Such continuing education for attorneys is now mandatory under Iowa law. Obviously, it is an effort by the Bar and the Court to prod the average attorney into sharpening his skills. Withdrawal of licensure is the penalty for those who do not comply.

The above-mentioned seminar was the first such program to receive the accreditation necessary to count toward the 15-hour requirement. The event was extremely well attended by attorneys from all sections of Iowa. The program was excellent and covered many issues of medical-legal interest.

During the seminar, a well-meaning moderator, in a burst of enthusiasm, declared to the audience that if only doctors would attend meetings such as this there would be much less medical malpractice. There was a murmur of self-satisfied approval and the meeting adjourned.

Dr. Ravreby is in the private practice of both medicine (internal medicine) and law in Des Moines. He is a member of the Iowa Medical Society Medico-Legal Committee.

Is this the simple solution to malpractice—15 lecture hours per year?

The truth is that physicians attend infinitely more educational sessions per year than attorneys. They meet in study clubs, attend hospital staff meetings, and participate in general and specialty programs at the local, state and national levels. They receive a flood of solicited and unsolicited educational material in each day's mail. And, so saying, I must admit that every physician has educational deficiencies which expand at an alarming rate after some 10-15 years of private practice.

MEDICAL KNOWLEDGE

I do not believe the lawyer or the layman understand the phenomenon represented by medical evolution. Laymen deal in subtle changes and only rarely with abrupt reversals in their technical or vocational lives. On the other hand, from every corner of the world, literally every corner, discoveries or extensions of medical facts (new insights and improvements in technology) are added regularly to the total fund of medical knowledge which by its total impact frequently erases years of conditioned thinking or makes obsolete some mode of diagnosis or therapy. It creates a new standard of care, the measure by which the law examines the delivery of health care.

To compound this disadvantage, the law allows 12 laymen, a jury, to decide what the standard shall be when there may be conflicting testimony directly on a point. Even with this being the case, I do not propose radical change. I am proud of the giant strides in medicine and am impressed by the ultimate wisdom of the law.

When a masterpiece of art is damaged or a

(Please turn to page 442)

Professional Liability Insurance

HOWARD D. BAKER
Waterloo

The suggestion of this management counselor is to maintain liability coverage by adding premium increases to patient charges. He counsels that this approach has greater logic than dropping insurance or quitting practice.

On occasion we all let emotion override logic. In the past several years we have probably all been guilty of doing this with regard to professional liability insurance premiums.

Professional Management Midwest is on record as believing strongly that liability insurance premium increases have been unjustified. While the frequency and amounts of malpractice awards have risen sharply, we contend these increases are nowhere near proportionate to the premium increases. We also believe strongly that the insurance industry should be required to make full financial disclosure to justify their increases.

However, no matter what our feelings and beliefs, the premium increases have occurred, and we are challenged to make decisions on how to cope with this rapidly mounting cost.

Various options have been advanced: *to go out of practice, to drop insurance coverage,* or *to attempt to avoid judgments through gifts and trusts.*

In the final analysis, none of these alternatives are workable or realistic. They are all more emotional than logical.

Whether we are dealing with medicine, farming, manufacturing or retailing, the pricing of a product or service is based upon the cost of producing the product or service, plus a fair profit.

COST INCREASES

Physicians have been dealing with cost increases in other areas for years. Rents, salaries, taxes, supplies, and equipment costs have all gone up sharply and these logically have been reflected in the charge to the patient. When rent went up, the alternative of practicing in a tent was never considered—doctors raised fees to cover the cost.

It is our belief that doctors must continue to carry adequate professional liability insurance—no matter what the cost. It also follows logically that as professional liability premiums increase, these increases must be passed through to the patient as a part of the cost of medical care—the same as rent, salaries, or taxes.

A good deal of the emotional reaction occurs upon receipt of the premium notice. An anesthesiologist who paid a $4,000 premium in 1975, may receive a renewal notice with an $11,000 premium. This is a $7,000 (175%) increase and the first reaction is the *quit practice, drop insurance,* or *transfer assets* reaction.

Let's take another look. Our average anesthesiologist does about $120,000 annual volume. This means that the $7,000 premium increase is a bit less than 6% of his gross income. If a "unit" of service is priced at $15, a 6% increase would be 90 cents—round this off to $16—this does not

(Please turn to page 443)

Mr. Baker is Manager of the Financial Planning Department of Professional Management Midwest.

PERSPECTIVE ON MEDICAL LIABILITY

(Continued from page 440)

prize animal is destroyed by fire, we grieve at the loss but are consoled by the healing poultice of dollars from insurance proceeds. Much of our civilized world values human life even above its most treasured works of art. When the doctor fails or is careless or is wrong in judgment about the human body, he may be sued for money damages that are astounding.

Time was when malpractice suits were not fashionable. In the United States we move with the rhythm of the flock. The hair shortens, the hair lengthens, the skirt shortens, the skirt lengthens. Attitudes toward sex, smoking, marriage and religion ebb and flow like the tide. Today's patient does not feel ill at ease over a potential suit against his doctor. It's in vogue, his peers will accept the action, and it is his constitutional right. It has been my experience that very few lawyers in this community will accept malpractice suits that are groundless. They are practical and honorable men and women. They consult, they ponder, they research, and they reject, as well as contend vigorously in behalf of their clients.

The malpractice we see even today is but the tip of an iceberg. Every doctor should know this. For every misadventure brought to the attention of an attorney, hundreds survive by the grace of God or return to His bosom in undiscovered peace. We have no need for vigilante committees or doctor informers. I ask only that we understand the problem and place it in perspective.

New laws and new attitudes may help, but the problem will survive and will continue to flourish for some time. The technology and responsibilities of medical practice are caught in a struggle with public expectations and professional capabilities, consequently change is in the wind. But hasty solutions are not the answer. The answer will come with thoughtful evolution.

Effective delivery of health care is vital to the American life style and the problem of medical malpractice must not be the tail that wags the dog. Patience and understanding are essential.

NEW MEDICAL LIABILITY DATA IS EMERGING

IN THE SEARCH for answers/solutions to the medical liability problems plaguing Iowa and the nation, the persistent call from lawmakers and others has been for solid information to support specific remedial action.

Frankly, such information has been elusive and often non-existent. It still remains in a somewhat inconclusive state. Apparently, medical liability insurance has resided traditionally in a sort of a miscellaneous catgory and has received analysis on a conglomerate basis.

In the wake of the recent and ongoing turbulence, with its startling premium increases and its scarcity of coverage—and with the inevitable pass through of premium costs to patients—data-gathering has begun to receive deserved attention. Stepped-up efforts are being put forth to amass meaningful information.

One significant effort is the study of the National Association of Insurance Commissioners. The NAIC study is of all claims closed (between 7/1/75 and 7/1/76) by companies that write a million or more dollars of medical liability premium. The third of four quarterly reports contemplated in the study became available in October.

Extensive statistical data is contained in the NAIC reports. Both qualitatively and quantitatively, the study appears to hold considerable potential. However, it will take some time to ascertain from the findings just how useful they will be in inspiring and supporting additional legislation or other new approaches.

The NAIC statistical presentations are basically countrywide in nature. There are one or two state-by-state analyses which permit some comparative opportunities. For example, in the approximate nine-month period covered, Iowa is reported to have had 75 liability claims closed either with or without payment of an indemnity. It should be observed the incidents may have occurred several years prior but the case is just now being closed.

Of the 75 claims, 46 involved some form of

PROFESSIONAL LIABILITY INSURANCE

(Continued from page 441)

represent a prohibitive increase by any means. Under this new structure, a procedure requiring 4 units would now be priced at $64 rather than at $60, and 8 units would be $128 rather than $120. This alternative is far superior to leaving practice or dropping insurance coverage.

RANGES DOWNWARD

In other specialties, the increases in insurance premiums, as related to gross charges, are ranging from 6% down to as little as 1% to 2%. The logical conclusion is that when you relate the premium increase to gross charges, it takes on a completely different perspective as compared to relating it to the premium level.

We have had cases where clients have reduced coverage to save $800 to $1,000 in premium. We believe this is false economy as compared to a nominal 1% or 2% increase in charges. Even if a premium increase amounted to 10% or 20% of charges, our position is that the coverage should be retained and the cost passed on to the patient.

We believe physicians must continue to campaign and fight for malpractice reforms, but in the meantime, we also believe that they should maintain their insurance coverage at a high level, pay the premium and pass the increased cost on to the patient. For the long-term future we do not believe that any other alternative is at all adequate.

TAX FACTORS

Finally, do not lose sight of the tax status of the increased premium. It is a fully deductible expense, meaning the after-tax cost to the doctor will be about one-half of the stated increase. If the increase is in the range of $800 to $2,000, after tax income would go down $400 to $1,000, and a doctor may logically elect to absorb this cost without an immediate fee increase.

Whatever the case, the doctor should not overreact, but should consider logical alternatives and discuss the matter, in depth, before making a final decision.

IN THE PUBLIC INTEREST

money payment and 17 payments exceeded the $10,000 level. By applying a physician census figure, the study shows a 2.50 claim incidence per 100 Iowa physicians (with 1.54 per 100 where damages were paid and 0.57 per 100 where damages were paid above $10,000). For comparison, the national incidence was 3.49 per 100 physicians; 1.41 per 100 where any damages were paid, and 0.56 per 100 where damages above $10,000 were paid.

In a state-by-state listing of large claims (those in excess of $50,000), Iowa is noted as having three such claims closed over the past nine months. The total amount of indemnity paid is $411,525. Separate sums of $66,000, $90,000 and $255,525 make up the total and are said to cover all defendants. Iowa appears to have had three of 405 such $50,000-plus cases countrywide.

Other NAIC findings in brief and at random include:

- Claims against physicians and surgeons constitute 60% of claims by count and 71% by amount paid; claims against hospitals are 35% in number and 26% in amount paid.
- Specialties with the most malpractice claims and having percentages above the average of claims incidence for all specialties include (the percentage above is shown in parentheses): general practice with surgery (388%), cardiovascular surgery (338%), neurosurgery (300%), thoracic and orthopedic surgery (275%), plastic surgery (225%), obstetrics (188%), anesthesiology (163%) and urological surgery (138%).
- Hospitals and emergency rooms are the site of injury for 79% of the incidents by count and 84% by amount paid. Physician's offices are the site for 15% of the incidents and 12% of the amount paid.

Probably the most useful category of information in terms of statutory revision, particularly as it may pertain to a new definition of malpractice, is the one which contains data on diagnosis, missed diagnosis, procedures causing injuries, etc.

It will be interesting to see how this extensive data is applied to the problem.

DETECTION OF N. GONORRHOEAE VIA JEMBEC SYSTEM

In cooperation with the State Hygienic Laboratory, the Iowa State Department of Health is introducing a new laboratory system to detect *N. gonorrhoeae* infection. The Jembec system of bacteriologic culture is a simplified technique to replace Transgrow bottles which have been used successfully the last four years. In the 12 month period ending June 30, 1976 a total of 74,516 Transgrow and Thayer-Martin culture specimens were processed under the Iowa gonorrhea screening program. Of these, 2,455, or 3.29 percent, were positive. As with Transgrow, the use of Jembec plates should be restricted to females under 30 years of age and to asymptomatic males who have been exposed to a diagnosed case.

The Jembec system, with Modified Thayer-Martin (MTM) medium, is selective for growth of pathogenic *Neisseria* only. The system uses a rectangular plate with MTM medium, a CO_2 generating tablet and a polyethylene Jembec Bag. These provide the nutrients and CO_2 necessary for the culture of *N. gonorrhoeae*. Transportation of the specimen to the laboratory is facilitated by a light-weight, easy-to-use, padded mailing envelope.

The validity of cultural results depends on proper techniques in obtaining, inoculating and handling of specimens. The following instructions were developed by the State Hygienic Laboratory. They accompany each shipment of media and should help to ensure that maximum efficiency is obtained from the Jembec system.

I. STORAGE AND SHELF LIFE

Store plates in a refrigerator, if possible. Store CO_2 generating tablets and Jembec Bags at room temperature. *Do not allow plates, tablets or bags to freeze* or be exposed to excessive heat. The expiration date is noted on each individual plate. Do not use the Jembec plates or CO_2 tablets after the expiration date. *Do not use plates, tablets, or bags if they display any evidence of degradation.* Remember that the shelf life for the Transgrow bottles was three months. It is important to decrease the size of orders for Jembec plates so that they will be used within four weeks.

II. INOCULATION OF JEMBEC PLATE

Medium should be warmed to room temperature before inoculation.

1. Open plate and roll specimen swab directly on the MTM medium in a "Z" pattern to assure adequate exposure of the swab to the medium.
2. Cross-streak with a sterile wire loop or the tip of a sterile swab.
3. If specimen is taken with a bacteriological loop (i.e. a urethral), streak the entire surface of plate so as to obtain isolated colonies.
4. Using forceps carefully place CO_2 Generating Tablet into well of plate.
5. Close Jembec plate immediately making sure lid fits *tightly.*
6. It is *not* necessary to moisten the CO_2 Generating Tablet; moisture is supplied by the medium.
7. Place Jembec plate in the polyethylene Jembec Bag and seal bag securely.

III. INCUBATION AND SHIPMENT

1. When possible, incubate the Jembec plate at 35-37°C overnight before mailing, and note time of inoculation and length of incubation on accompanying report form. Bacterial growth survives transport better if preincubated.
2. If incubator is not available, keep specimen at *room temperature* until shipment. During cold

weather months, when outside temperatures are below 18°C, please incubate plates at room temperature prior to mailing. During warm months, if incubation is not available, please mail as soon as possible.

3. Package the completed laboratory data form and the bagged Jembec plate in the mailing envelope to prevent breakage during transport to the laboratory.

IV. SELECTION OF CULTURE SITE—WOMEN

A. Endocervical Canal

1. Moisten speculum with warm water; do not use any other lubricant.

2. Insert sterile cotton-tipped swab into endocervical canal to the point where it is free-standing; move swab from side to side; allow 10-30 seconds for absorption of organisms onto the swab.

B. Anal Canal

1. Insert sterile cotton-tipped swab approximately one inch into the anal canal.

2. Move swab from side to side in the anal canal to sample crypts; allow 10-30 seconds for absorption of organisms onto the swab.

C. Urethra or Vagina (cultures are indicated when the endocervical culture is not possible; e.g. hysterectomy patients and children).

1. Urethra
   a. Strip the urethra towards the orifice to express exudate.
   b. Use sterile loop or cotton swab to obtain specimen.
2. Vagina

Use speculum to obtain specimen from the posterior vaginal vault or obtain specimen from the vaginal orifice if the hymen is intact.

D. Oropharynx (a common local source for disseminated gonococcal infection).

Swab the posterior pharynx and tonsillar crypts with a cotton-tipped applicator.

V. CULTURE SITE—MEN

(Gram stained smear of urethral exudate is usually satisfactory for diagnosis of acute, uncomplicated gonorrhea in males.)

A. Urethra

Use sterile calcium alginate urethral swab to obtain specimen from anterior urethra by gently scraping the mucosa. A sterile bacteriologic wire loop that is easily inserted into the urethra may be used.

B. Anal

Taken in same manner as for women.

C. Oropharynx

Taken in same manner as for women.

Reports from several other states which have changed from the Transgrow to the Jembec system indicate an increase in positivity rate. The Jembec system, which is more convenient and easier to use, hopefully will provide the Iowa physicians with a detection mechanism superior to the former Transgrow system.

To order Jembec media, write or phone:
State Hygienic Laboratory
The University of Iowa
Medical Laboratory Building
Iowa City, Iowa 52241
Telephone: (319) 353-5990

MERCY HOSPITAL CONTINUING MEDICAL EDUCATION PROGRAM

The Mercy Hospital Visiting Lecture Program in Des Moines is an ongoing continuing education event open to interested Iowa physicians. Dates, speakers, and lecture topics for coming weeks are as follows—November 17, Robert Townley, M.D., professor of medicine and microbiology, Creighton University, "Recent Advances in Asthma and Emphysema"—December 1, Robert Soper, M.D., professor of surgery, U. of I., "Neonatal Surgical Emergencies"—December 15, William Bell, M.D., professor in department of pediatrics and neurology, U. of I., "Neurologic Problems in Infancy"—January 12, Joshua Fierer, M.D., professor of pathology, Creighton University, "Immunological Aspects of Renal Disease"—January 26, W. C. Keettel, M.D., professor and head, department of obstetrics and gynecology, U. of I., "Current Thoughts on the Management of Menopause." Each lecture is approved by AMA for 1.5 hours Category 1 Continuing Medical Education credit. Approved AAFP prescribed credit: 1.5 hours per lecture. All lectures will be at 12:30 P.M. in Mercy Hall, Mercy Hospital, 6th and University, Des Moines, Iowa.

No. 3
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e.g. the pain of
sprains and strains

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- addiction liability low

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SCIENTIFIC ARTICLES

Examination of the Alleged Rape Victim

STEVEN C. JOHNSON, M.D. and
CHARLES A. dePROSSE, M.D.
Iowa City

Discussed here is the protocol followed at The University of Iowa College of Medicine in the care of the alleged rape victim. Both physical and emotional needs receive careful attention.

THIS PAPER PRESENTS an organized protocol for use in evaluating alleged rape victims. Particular attention is given the emotional aspects of the initial evaluation inasmuch as this is the crucial time for providing adequate care to these patients. Use of a simple and non-judgmental form covering examination and treatment should serve to increase the percentage of women reporting rape. As a result, there should be an increase in the number of people who request evaluation and treatment for both their physical and psychological needs. Also, the provision of well documented evidence should in turn cause an increase in the number of rape cases successfully prosecuted.

Dr. Johnson is a former senior resident in Department of Obstetrics and Gynecology at the University of Iowa College of Medicine and is now located at Seymour-Johnson Air Force Base in Goldsboro, North Carolina. Dr. deProsse is an assistant professor in Department of Obstetrics and Gynecology.

Sexual assault is increasing in frequency. During recent years much emphasis has been placed upon care of the rape victim. Also, there has been increasing concern for the immediate social, legal and medical problems, as well as the long term effect on the alleged victim of sexual assault.

One of the problems in this area has been the lack of a comprehensive procotol to aid in the evaluation of these patients. This situation has caused anxiety for the patient as well as the physician who performs the examination.

At the University of Iowa Hospitals, a protocol has been developed which provides the physician with a guideline to follow. This helps to eliminate oversights in the evaluation of these patients. It sets forth comprehensive examination procedures to produce information to aid in making an assessment of both the patient's physical and emotional well being. Additionally, it assures the gathering of accurate legal evidence.

At most university or large hospitals these patients are seen in an emergency room setting and are examined by house staff personnel. However, in certain urban and rural areas without such house officers, the patients are seen by local physicians. Although these physicians are aware of the problem, they do not have a comprehensive protocol to follow in the evaluation of victims of sexual assaults. The completeness and accuracy of the history obtained, the examination performed and the laboratory data procured are all

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF NOVEMBER 1976.

CONSENT FORM FOR MEDICAL REPORT ON
SUSPECTED RAPE

Name of Patient: _____ (last) _____ (first) _____ (mid. init.)

Address: _____ (number and street)

_____ (city) _____ (state) _____ (zip)

Admitted to Emergency Room: _____ (date) _____ (time)

Name of Police Official with Patient: _____ (last) _____ (first)

AUTHORIZATION FOR COLLECTION OF EVIDENCE AND RELEASE OF INFORMATION

I hereby authorize the University Hospital, the Obstetrics and Gynecology Department, and the Department of Student Health to collect any blood, urine, tissue, or other specimen needed and to supply copies of all medical reports including any laboratory reports, immediately upon completion to the Police Department and the office of the District Attorney having jurisdiction.

Person Examined (Signature) X_____

Date Signed _____

Signature of Witness X_____

Parent or Guardian Signature
(if required) X_____

CONSENT FORMS COMPLETED?
Physical Examination: YES NO
Collection of evidence and release of information: YES NO
Obtain photographs: YES NO

(The above can be obtained by the admitting nurse)

ASSAULT COMPLAINT: (Patient's own words; describe if force was used)

_____ (date) _____, M.D. (Examiner's Signature)

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Figure 1

HISTORY:

1. Age:
2. Gravidity: Parity:
3. Date of termination of last pregnancy:
4. Age of menarche:
5. Date of last menses:
6. Last menses normal: YES NO If no, describe:
7. Patient known to be pregnant: YES NO
8. Symptoms of pregnancy: YES NO If yes, describe:
9. Most recent coitus prior to alleged assault:
   _____ (date) _____ (time) Condom used? YES NO
10. Current mode of contraception (prior to alleged assault):
11. Patient states she is (was) virgin prior to assault: YES NO
12. Vaginal tampons used: YES NO Age begun: _____
13. Douching practiced: YES NO Most recent: _____
14. During alleged assault:
    Did penis penetrate vulva? YES NO
    Assailant experience orgasm? YES NO
    Assailant wear condom? YES NO
    Did penis penetrate rectum? YES NO
    Did a foreign object penetrate rectum? YES NO
15. Since alleged assault has patient:
    Douched? YES NO
    Bathed or showered? YES NO
    Defecated? YES NO
    Urinated? YES NO

_____ (date) _____, M.D. (Examiner's Signature)

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Figure 2

16. Has patient knowledge of:
    any present illness? YES NO
    any present medication? YES NO
    any drug allergy? YES NO
17. Has patient had a venereal disease (past or present)? YES NO
    If yes, describe therapy:
18. History of emotional illness: YES NO
    describe:
19. Previous vaginal surgical procedures: YES NO
    describe:
20. In 24 hours prior to alleged assault did patient use alcohol or illicit drugs?
    YES NO
    Describe date, time and amount of ingestion; frequency of use; duration of use; usual amount of intake.

Figure 3

important in both the medical care and the legal involvement of these persons.

Improvement in the evaluation of these patients will have the following favorable results:

1. The patient will feel she is being adequately evaluated and thoughtfully treated.
2. The physician will be more at ease in the performance of his examination and more secure in obtaining adequate specimens and evidence.
3. The patient's emotional well being will be better served by the physician as the protocol requires little effort to complete.

THE PROTOCOL

The first page of the protocol involves obtaining informed consent for all procedures to be done and specimens to be collected. This can be completed in the presence of a nurse, who can then sign as a witness. (Figure 1.) The lower portion and the reverse side of this form provides space for a description of the incident in the alleged victim's own words. Physicians are not interrogators!

The history is meant to aid in further medical and emotional evaluation and care of the patient. (Figures 2 and 3.) Pertinent points in the history are listed. The answers, *yes* or *no*, can be circled or checked. These are important in evaluating the patient for a recent assault.

Following this the physical exam is outlined and a diagram of the perineum is provided on

PHYSICAL EXAMINATION:

1. B.P._____Pulse _____Temp._____Wt. _____Ht. _____
2. General Appearance:
3. Emotional Status:
4. Clothing: Stains? YES NO ; Foreign Material: YES NO
   describe:
5. Body Surface: Bruises? YES NO ; Scratches? YES NO
   Lacerations? YES NO
   describe:
6. Mouth:
7. Fingernails:
8. Pubic Hair:
9. Vulva:
10. Hymen:
11. Vagina (No Lubricant!):
12. Cervix:
13. Uterus:

_____ _____, M.D.
date Examiner's Signature

9/75

Figure 4

14. Adnexa:
15. Recto-vaginal:
16. Sketch of perineal findings: (Label all positive findings):

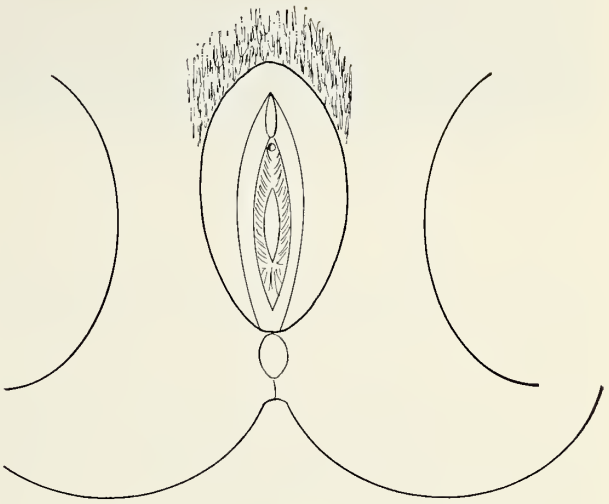

Figure 5

which areas of injury can be noted. (Figures 4-6.)

The final page of the protocol lists all specimens which must be obtained and any treatment which was administered (e.g. for venereal disease or prevention of pregnancy). Follow-up arrangements should be listed here. (Figure 6.)

Patient follow-up is a very important part of the overall evaluation. The following points illustrate this:

1. Cultures for gonorrhea are repeated to ascertain adequacy of treatment and/or investigate possible persistent or untreated disease.

2. A serological testing for syphilis is drawn to rule out acquisition of syphilis.

3. A physical exam is done to insure that all physical injuries have been treated adequately.

4. It is most important to discuss the situation with the patient to discover whether any further counselling will be necessary. Emotional support is one of the prime requisites for proper care of the victim of sexual assault.

COMMENT

Rape has occurred throughout history. It has however been an increasing form of violent crime. Treatment for rape should be both physical and psychological. It is *not* necessary that a

COLLECTION OF EVIDENCE:

1. Two tubes of clotted blood – labeled. (1. to Serology; 2. to Forensic Path. Lab.)
2. Scrape and trim fingernails into envelope and label.
3. Comb and collect free pubic hair into envelope and label.
4. Cut off and label a few pubic hairs into separate envelope and label.
5. Collect any loose hair or dried blood and label (site collected).
6. Examine a saline wet mount for sperm: Present; YES NO ; Motile? YES NO
7. Prepare four slides of vaginal contents or saline washing; place 2 in fixative, and leave 2 dry.
8. Do cervical culture for N. gonorrhea.
9. Place set cotton swab (wet with vaginal secretions) in dry test tube (semen typing).
10. If indicated:

    ---Urine for pregnosticon YES NO
    ---Wet & dry preps from mouth YES NO
    ---Urine for urinalysis of bladder trauma YES NO
    ---X-rays obtained (indicated because of trauma) YES NO
    ---Photographs YES NO

IMPRESSION:

RECOMMENDATIONS:

Treatment---
1. D.E.S. YES NO
2. Menstrual extraction YES NO
3. Penicillin & Probenemid YES NO

Appointments:

I HEREBY CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF THE OFFICIAL OFFICE AND/OR HOSPITAL RECORDS CONCERNING THE EXAMINATION OF THE ABOVE NAMED PATIENT.

_____ _____, M.D.
date Examiner's Signature

Results of laboratory procedures:

	date	results
1. Preg. test		
2. Serology		
3. N. Gonorrhea Culture		

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Figure 6

trained gynecologist provide care for alleged rape victims; other physicians or trained emergency room residents are adequately skilled to treat these patients. The quality of treatment depends upon training, availability and desire to do the work involved. Whoever treats the victim should do it well *with both serious concern and dignity.*

Even though physical injuries are very important, the patient's state of mind is frequently the most pressing medical concern following a sexual assault. This is an ongoing problem which requires a sympathetic ear and a sensitivity to needs for further counselling. Pregnancy and/or venereal disease may become urgent medical sequelae of rape, but persistence of traumatic emotional reactions often become much more important.

It has been stated that many responsible individuals avoid caring for the alleged rape victim. In greater Chicago, an area with over seven million people, there are only six hospitals willing to care for these patients.

Victims of rape go through several emotional stages: first, acute distress, shock, anxiety and dismay; second, several weeks of "pseudoadjustment" (in which period of time the patient and her family appear to have accepted the facts as they are): third, after several weeks the patient may develop depression and an inability to cope with things in general. The third and final stage is very important to recognize and treat.

SUMMARY

We have presented a standardized easy-to-follow protocol for the care of the alleged rape victim. The physical and emotional needs of the patient are discussed. The importance of adequate follow up is stressed.

FORMS

The figures shown with this paper have been reduced due to space limitations. Full 8½ x 11 copies of the University of Iowa forms may be obtained from the authors or the Iowa Medical Society.

★

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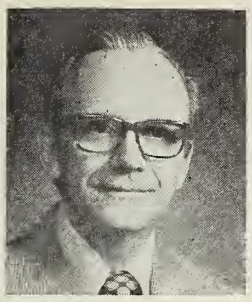


Editorials

M. E. ALBERTS, M.D., Scientific Editor

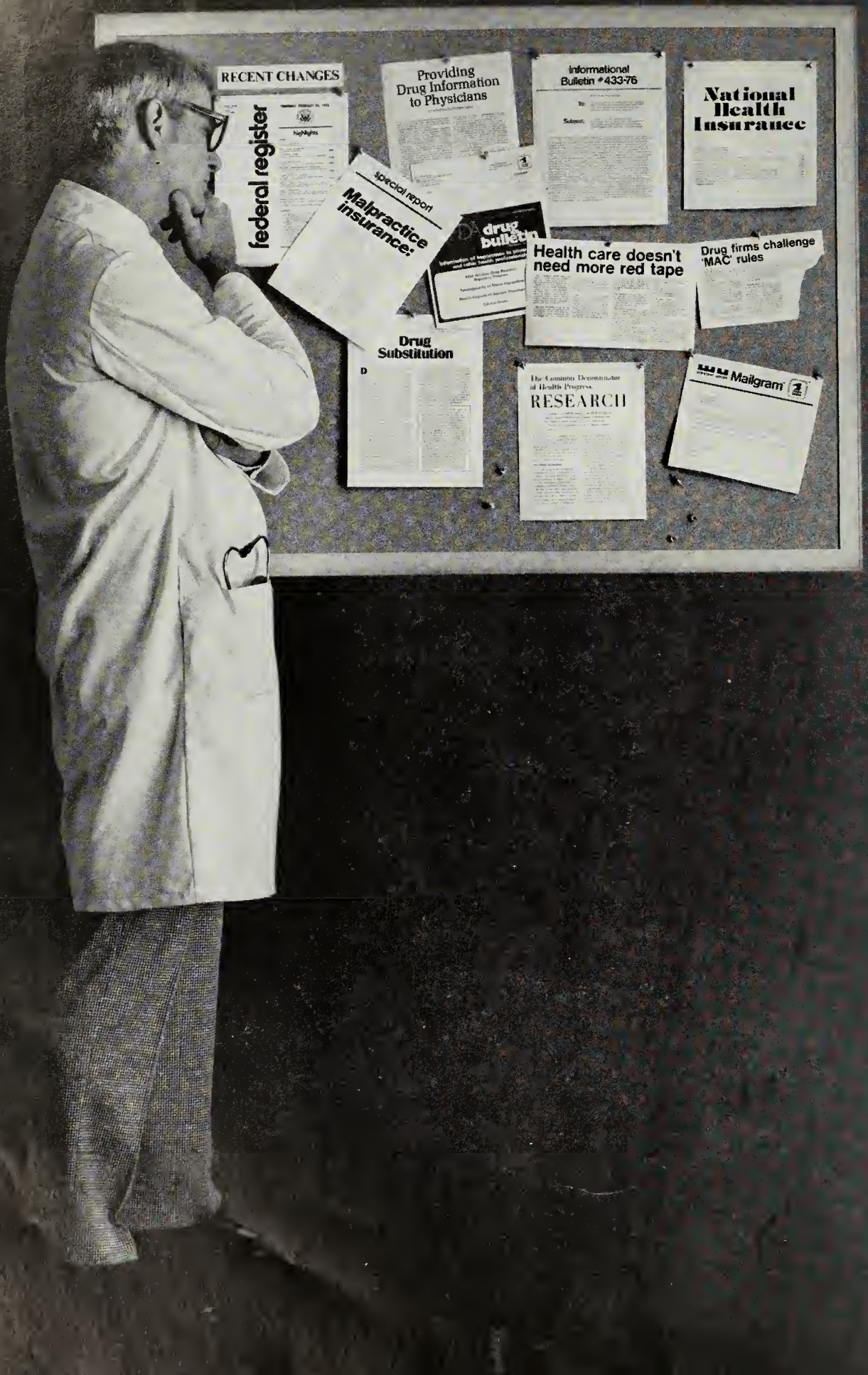
THANKS TO A RUSTIC CHAIR

The rustic sign indicated the narrow graveled road to be a cross-country ski trail. Coursing through the pine trees on the western slopes of Colorado, the road beckoned to enter and follow. It was a challenge to imagine the appearance of the ski trail when covered by a blanket of snow. The density of the trees and undergrowth increased rapidly as I walked out of sight of other evidence of human habitation. Yet another trail, away from the graveled road, caught my eye. It too beckoned. I yielded.

The narrow path was cushioned by the accumulation of many years' shedding of pine needles, soft and pleasantly yielding to my boot-clad feet. Within a few steps the road was lost to view and only the faint path led into the dense woods. Where would this lead, I pondered. Was this meant only for animals wending their way to a watering spot? Would I intrude upon a part of creation not designed for me? The path continued to draw me onward, until I finally came to a small mountain stream, rushing recklessly toward lower altitudes and ultimately a river. The water was clear; the rock-covered bottom a myriad of colors enhanced by scattered growth of underwater plants. Surely a few trout lurked in the shadows. A tree fallen across the stream provided a way to go onward.

In time I became aware someone before me had discovered this bit of heaven on earth. On the opposite bank of the creek was a rustic chair built against the backdrop of a huge boulder. I accepted the hospitality, sat upon the chair, and thereupon realized why it had been built in this hidden place. To the left and far ahead came the waters of the stream coursing noisily down through the trees to the clearing . . . tumbling water seeking freedom from the rocks which attempted to impede the flow of the product of melting snow. Ahead through the trees the distant mountain tops proclaimed dominion over the pines and aspen bowing before them. The mountain tops in turn were crowned by an azure blue sky festooned with pure white fluffs of clouds. To the right was a rocky bank covered with many and varied flowers—pink, white, blue, red, yellow—all enhanced by varying shades of green foliage. Here it all was . . . peace, quiet, solitude . . . surely an altar for communion with nature and the Omnipotent. I envied the mortal who built that chair, for he truly must have spent pleasant hours musing in that marvelous setting. If only it could last forever. After a short time reality struck me, for across that mountain top, crowned by the blue of the heavens, was the "contrail" of an airliner rushing to the west.

Reality was cruel at that moment. The airliner reminded me of our constant rush. We are forever thrusting forward, faster and faster, trying to strive for something or break away from some bonds that seem to surround us. In a few days I would be back in the office, surrounded by crying infants, boisterous pre-schoolers, anxious mothers, and mountains of paper-work. Couldn't it all be thrown aside? Why not chuck it all aside and become free? Yet, what is it all about? Who can do a foolish thing like that? Later I wished I had taken a photograph of that mountain retreat, but then even later thoughts provided thanks that I hadn't. The imprint engraved on my memory will be more permanent and true to the initial impression than a chemical imprint upon a piece of photographic paper. Once reality had struck down my thoughts, I departed from the rustic


RECENT CHANGES
federal register
Highlights
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
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RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

EDITORIALS

(Continued from page 451)

chair looking back two or three times as it disappeared behind the trees as I followed the tiny forest path back to the coarse reality of civilization.

Thoughts such as these must let us be thankful that we can have reality as part of our life, but also that there are moments of peace and solitude. There is beauty of life and nature all around us, so close, but yet sometimes too far. When a small path beckons to such a moment, follow it, and seek out something more than the constant battle of civilization (whatever that is). We are mere mortals, here only on a short-term loan. We serve as we may, and have allocated to us a fair share of the joys of love, and of happiness, and the opportunity to aid others. Truly we must be thankful for all that and more. These are my thoughts at this Thanksgiving Season. May you have similar feelings as you count your blessings at the Thanksgiving table.—M.E.A.

MEDICAL MISCELLANY

BUDGET SESSION . . . The IMS Board of Trustees will finalize its 1977 budget at a meeting in Des Moines on December 15.

PHYSICIAN NAMED . . . John Tyrrell, M.D., Manchester, has been named to the State Health Coordinating Council (SHCC) by Governor Ray. The 30-member unit is required by P.L. 93-641 (the Health Planning & Resources Development Act of 1974). Dr. Tyrrell is also one of four medical doctors who serve on the Iowa Health Systems Agency (HSA). The SHCC will be advisory to the State Health Planning and Development Agency (Department of Health) and will have authority over the State Health Systems Plan and Medical Facilities Plan. Vera French, M.D., Bettendorf, is another physician named by Governor Ray to the State Health Coordinating Council.

IFMC-IMS RELATIONS . . . In late September, the Iowa Foundation for Medical Care and the Iowa Medical Society approved memoranda of understanding which cover the establishment of a liaison committee for nomination purposes and bear on other matters of mutual interest. In addition, the Foundation, which is the Iowa PSRO, has consummated a memorandum of understanding with the Iowa Health Systems Agency (HSA) which covers specific areas of cooperation and liaison, including exchange of appropriate aggregate data that may be mutually beneficial.

NEW DRUG ABUSE DIRECTORY . . . A new Directory of Iowa Drug Abuse Services has been prepared recently by the Iowa Drug Abuse Authority. Copies of the Directory were circulated to IMS members with the October UPDATE.

LEGISLATIVE COMMITTEE . . . The IMS Committee on Legislation met October 7 to begin setting priorities for the 1977 session of the Iowa General Assembly. Professional liability will continue as the key issue before the Committee. Appropriation bills for Medicaid and the Family Practice Residency Program will also have priority status. Other measures to which the Society will give attention include radiation control, certificate of need, compulsory immunization, corporate practice rule, optometric use of diagnostic drugs, ownership of records, and expansion of chiropractic.

NORTH CENTRAL CONFERENCE . . . IMS officers will participate November 6 and 7 in the North Central Medical Conference in St. Paul, Minnesota. The NCMC involves five states—Iowa, Minnesota, Nebraska, North and South Dakota.

INTERIM STUDY . . . Second meeting of the General Assembly Interim Committee on Liability Insurance occurred October 4 and 5 with the IMS requested to supply further information of physician economics. The current study, in addition to covering medical liability, is also concerned with products liability, liability of municipalities, etc.

IOWA MEDICAL SOCIETY INSURANCE SERVICES AVAILABLE TO MEMBER PHYSICIANS

On the following two pages is a summary of the insurance coverages which are available from the Iowa Medical Society. All member physicians are invited and encouraged to review this outline to see if and where any of these coverages may fill a void in or supplement an existing individual insurance program. This suggestion is directed particularly to those physicians who are new to the membership of the Society.

The Committee on Group Insurance of the Iowa Medical Society is responsible for the periodic evaluation of these programs to determine their value and receptivity. It is the further duty of the Committee to consider and recommend appropriate new coverages.

On the final page is a brief listing of those insurance coverages which are available to IMS member physicians who are active in the American Medical Association.

Any questions or comments regarding these programs may be directed to the administrator as shown or to the Headquarters of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265 (Telephone—515/223-1401)

TYPE	COVERAGE	SPECIAL FEATURES
1. INCOME PROTECTION (ACCIDENT AND SICKNESS DISABILITY)	Optional Amounts Up to $300 Weekly ($1,300 Monthly) and Benefit Durations Up to Lifetime for Accident and to Age 65 for Sickness. Program Automatically Includes $1,000 Accidental Death & Dismemberment, Waiver of Premium, a Rehabilitation Program and Loss of Use of Hand or Hands Benefit. Future Increase Option Available.	Benefits Begin First Day of Disability for Accident and Earlier of Eighth Day Disabled or First Day Hospital Confined for Sickness. Optional Plans Available With Benefits Beginning the 29th Day, 57th Day, 92nd Day or 183rd Day. Claims Paid Directly From Administrator's Office. Special Renewal Features and Conversion Option Automatically Included.
2. OFFICE OVERHEAD DISABILITY COVERAGE	Available From $200 Monthly to $2,000 Monthly as Reimbursement for Office Expenses (Rent, Employee Salaries, Utilities, etc.) Incurred During Insured's Disability.	Benefits Begin After Waiting Period of Either 14 Days or 30 Days With Benefits Payable Up to 24 Months. Premium Tax Deductible. Special Renewal Features and Conversion Option Automatically Included.
3. TERM LIFE INSURANCE	Available in Amounts From $10,000 to $50,000. Guaranteed Renewable and Convertible to Age 70. Special Plans Available for Members of IMS Auxiliary in Amounts From $5,000 to $25,000.	Individual Policies. Renewal Rate Guaranteed. Waiver of Premium. Double Indemnity. Full Conversion Privilege Any Time. Dividends Reduce Premium.
4. EXCESS MAJOR MEDICAL	Pays 100% of Eligible Expenses After $10,000, $15,000, $20,000, $25,000 or $50,000 Deductible Is Satisfied. Once Deductible Is Satisfied Plan Pays Up to $300,000 per Person.	10-Year Benefit Period. 36 Months in Which to Satisfy Deductible. Guaranteed Issue. Renewable for Lifetime.
5. HIGH LIMITS ACCIDENTAL DEATH AND DISMEMBERMENT	Accidental Death, Dismemberment, Loss of Sight, Permanent and Total Disability Feature. Available From $25,000 to $150,000—Wife & Family Coverage Also Available.	24-Hour, World Wide Coverage. Aviation Coverage as Passenger. 365 Day Coverage. Renewable to Age 70. No Medical Underwriting.
6. HOSPITAL/MEDICAL	Two-option Coverage Available to Physicians, Their Families and Employees. Excellent Benefits to Cover Both Hospital and Medical Services.	365-Day Comprehensive Hospital 365-Day Blue Shield UCR. Nervous, Mental, Drug Addiction, TB and Alcoholism. Major Medical Optional.
7. WORKERS' COMPENSATION	Provides Workers' Compensation Coverage as Required by State Law. Approved Rates Are in Effect. Program Meets Employer's Obligations for Occupational Injuries to Employees.	Is a Savings Plan in That Dividends Are Paid Based on Experience. 35% Return of Premium Has Occurred With Higher Percentage Possible. Safety Counsel Is Provided.

VA MEDICAL SOCIETY MEMBERS

ADMINISTRATORS	INSURANCE COMPANY	ELIGIBILITY AND HOW TO APPLY
The Prouty Company 2130 Grand Avenue Des Moines, Iowa 50312	Commercial Insurance Company Newark, New Jersey	New Members Eligible for Base Amount of Coverage Regardless of Medical History, if Application Is Made in 90 Days of Membership. All Insurable Members Eligible Anytime Prior to Age 56. Coverage Continues to Age 70 for Active Members. Special Plan Available After Age 70. Apply to Administrator—1-515-243-5255 or Toll Free—1-800-362-2860.
The Prouty Company 2130 Grand Avenue Des Moines, Iowa 50312	Commercial Insurance Company Newark, New Jersey	Applicant Must Be in Active Practice, under age 60, and Member of IMS. Apply to Administrator—1-515-243-5255 or Toll Free—1-800-362-2860.
The Prouty Company 2130 Grand Avenue Des Moines, Iowa 50312	Bankers Life Company Des Moines, Iowa	Any Active Member Under the Age of 65 May Apply. Apply to Administrator—1-515-243-5255 or Toll Free—1-800-362-2860.
The Prouty Company 2130 Grand Avenue Des Moines, Iowa 50312	Insurance Company of North America Philadelphia, Pennsylvania	All Members, Their Families and Employees. Apply to Administrator—1-515-243-5255 or Toll Free—1-800-362-2860.
The Prouty Company 2130 Grand Avenue Des Moines, Iowa 50312	Insurance Company of North America Philadelphia, Pennsylvania	Any Active Member Under the Age of 65, Spouse, and/or Family. Apply to Administrator—1-515-243-5255 or Toll Free—1-800-362-2860.
Blue Cross/Blue Shield Ruan Center Des Moines, Iowa 50309	Blue Cross/Blue Shield Ruan Center Des Moines, Iowa	All Members, Their Families and Employees. Apply to Blue Cross/Blue Shield.
Casualty Reciprocal Exchange Dodson Insurance Group P.O. Box 559 Kansas City, Missouri 64141	Casualty Reciprocal Exchange Dodson Insurance Group P.O. Box 559 Kansas City, Missouri 64141	Approved by the Iowa Medical Society for All Members. Apply to Casualty Reciprocal Exchange.

INSURANCE PLANS AVAILABLE FROM THE AMERICAN MEDICAL ASSOCIATION

GROUP LIFE INSURANCE

$25,000 or $50,000 Term Life Insurance, including double indemnity for accidental death and waiver of premium. Benefits begin reducing after age 65. Coverage renewable to 75. Application for coverage must be made prior to age 60.

GROUP DISABILITY INCOME

Provides $500, $750 or $1,000 monthly benefit after a 6-month or 12-month waiting period has been satisfied. If disability occurs before age 50 full monthly benefit is allowed for life. If disabled after 50 full monthly benefits are paid to 70. Partial disability benefits are included.

GROUP EXCESS MAJOR MEDICAL

Election may be made of $15,000, $20,000 or $25,000 deductibles. Once deductible is satisfied maximum benefit is $250,000. Deductible must be satisfied within 24 months. Once benefits begin they are payable for five years. Coverage is renewable to age 70.

GROUP IN-HOSPITAL INDEMNITY

Pays $50, $75 or $100 a day while the insured is hospitalized. Benefits are payable from the first day of hospitalization up to 500 days. Coverage can be renewed to age 65.

GROUP ACCIDENTAL DEATH & DISMEMBERMENT

Benefits are available from $100,000 to $300,000 in increments of $100,000. World-wide 24-hour coverage is provided. Plan has a permanent and total disability feature. Optional spouse and/or family coverage is available.

GROUP OFFICE OVERHEAD EXPENSE

Benefits are available from $500 to $5,000 monthly in increments of $500. A waiting period of 30 days is necessary before benefits begin. They are payable up to 36 months. Coverage is renewable to age 70.

For further information and application forms on the insurance coverages noted on this page please contact the William Mercer Company, 222 South Riverside, Chicago, Illinois 60606.

Cold/Allergy and Cough Country

Rynatan® Country

RYNATAN, for symptomatic relief of colds and allergic rhinitis. Convenient b.i.d. tablet and liquid dosage.

Rynatuss® Country

RYNATUSS, for symptomatic relief of coughs due to colds and in acute and chronic bronchitis. Convenient b.i.d. tablet and liquid dosage.

Mallinckrodt® Pharmaceuticals *Linking chemistry to medicine®*

Mallinckrodt, Inc. St. Louis, Mo. 63147

RYNATAN®: Each tablet contains Phenylephrine Tannate, 25 mg.; Chlorpheniramine Tannate, 8 mg.; Pyrilamine Tannate, 25 mg.

Each 5 ml. (1 teaspoonful) RYNATAN® PEDIATRIC SUSPENSION contains: Phenylephrine Tannate, 5 mg.; Chlorpheniramine Tannate, 2 mg.; Pyrilamine Tannate, 12.5 mg. CONVENIENT B.I.D. DOSAGE for convenience and economy.

INDICATIONS: RYNATAN provides symptomatic relief of the coryza and nasal congestion associated with the common cold. other upper respiratory infections and allergic rhinitis. In sinusitis, drainage from the affected sinuses may be improved.

CONTRAINDICATIONS: RYNATAN is contraindicated in those patients who are sensitive to sympathomimetic drugs.

PRECAUTIONS: Use with caution in patients with hypertension, hyperthyroidism, diabetes or coronary artery disease: warn of possible drowsiness in patients who may operate vehicles or machinery.

ADVERSE REACTIONS: Drowsiness and dryness of the mouth are occasionally associated with antihistamine therapy in some individuals.

DOSAGE AND ADMINISTRATION: RYNATAN TABLETS: 1 or 2 tablets every 12 hours.

RYNATAN PEDIATRIC SUSPENSION: For children over six years of age, 5 to 10 ml. (1 to 2 teaspoonfuls) every 12 hours: for children two to six years of age, 2.5 to 5 ml. (½ to 1 teaspoonful) every 12 hours; for children under two years of age, 1.7 ml. (⅓ teaspoonful) every 12 hours.

CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

RYNATUSS®: Each tablet contains Carbetapentane Tannate, 60 mg.; Chlorpheniramine Tannate, 5 mg.; Ephedrine Tannate, 10 mg.; Phenylephrine Tannate, 10 mg.

Each 5 ml. (1 teaspoonful) RYNATUSS® PEDIATRIC SUSPENSION contains Carbetapentane Tannate, 30 mg. Chlorpheniramine Tannate, 4 mg.. Ephedrine Tannate, 5 mg.; Phenylephrine Tannate, 5 mg. CONVENIENT B.I.D. DOSAGE for convenience and economy

INOICATIONS: In the treatment of coughs due to the common cold, asthma, and in acute and chronic bronchitis.

CONTRAINOICATIONS: RYNATUSS is contraindicated in those patients who are sensitive to sympathomimetic drugs.

PRECAUTIONS: Use with caution in patients with hypertension, hyperthyroidism, diabetes or coronary artery disease: warn of possible drowsiness in patients who may operate vehicles or machinery

ADVERSE REACTIONS: Drowsiness and dryness of the mouth are occasionally associated with antihistamine therapy in some individuals.

OOSAGE AND ADMINISTRATION: RYNATUSS TABLETS: Adults—1 to 2 tablets every 12 hours.

RYNATUSS PEDIATRIC SUSPENSION: For children over six years of age. 5 to 10 ml. (1 to 2 teaspoonfuls) every 12 hours: for children two to six years of age, 2.5 to 5 ml. (½ to 1 teaspoonful) every 12 hours; for children under two years of age, 1.7 ml. (⅓ teaspoonful) every 12 hours.

CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

The above represents a brief summary. See package inserts for full prescribing information.

Educationally Speaking

by RICHARD M. CAPLAN, M.D.

A MARKETING ORIENTATION TO CME, OR, WHAT'LL YOU HAVE?

This month I offer you a standing invitation. But first, a miscellany of observations:

Recently I experienced a visit to determine whether the University of Iowa College of Medicine shall continue to be accredited as a provider of continuing medical education. (Sometimes the word used is vendor, which clearly emphasizes the commercial aspect to the process.) I also recently have been reading a book that emphasizes the phrase "marketing orientation" in its application to service or not-for-profit institutions such as a College of Medicine.

These two experiences have made me focus some thoughts on the proper role of the "consumer" of the "educational product" in determining what that product ought to be. Some of the general theorists (and practitioners, too) of continuing education have argued and taught that the needs and goals for continuing education activities must logically and practically arise from the circumstances of the specific learner group that is to be served. This is often achieved by convening a planning group to offer the necessary "practical input."

Medical continuing education is somewhat different, though, in that its major rationale is not to serve the personal or intellectual or commercial interests (needs) of the physician, but rather, to produce an improvement in the quality of health care services received by our society. The focus should therefore be on what happens at the level of actual interface of the physician and patient, and what outcome is produced.

A continuing education purveyor is likely to be, in some measure, a bureaucratic organization. It is the nature of such organizations, as they grow increasingly specialized to achieve their aims, to grow increasingly rigid, resistant to change and relatively unresponsive to what might be termed its "market" or constituency. A College of Medicine is an example of such an organization. A tension naturally exists, then, between the bureaucratic and authoritarian approach to the development of the educational product, and the "responsive-to-the-consumer" approach to programming. To personalize, to hear the voice of the consumer, requires special energy and effort in a system that is and needs to be basically bureaucratic.

All this rather theoretical discussion is to lead me to invite you to be a part of the planning and developing of the CME that would matter to you. Whether you feel a personal need but require help knowing how to proceed, or whether you have ideas about educational offerings, learning strategies, evaluation procedures, ways to identify needs—for any of these, let me hear from you. The numbers of you who do so will, regrettably, be small enough that I can promise personal consideration and dialogue about your ideas. Please know that I genuinely want the continuing education effort of this College of Medicine to be responsive to the needs of you and your patients.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

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20/50 AS PRECIOUS

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20/20 TESTED LATELY A SI

20/15 COMFORTABLE HEARING

20/10 INVESTMENT OF A FEW MIN

Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

Professional Relations Division, Beltone Electronics Corporation
4201 West Victoria Street, Chicago, Illinois 60646

Beltone
WHEN A HEARING AID WILL HELP

About IOWA Physicians

Dr. Robert E. Rakel, professor and head of the U. of I. Department of Family Practice, was guest speaker at September meeting of Woodbury Medical Society. Dr. Rakel's topic was "Problem Oriented Medical Records." . . . **Dr. Jerry Dawson** recently opened a family practice in Estherville. Dr. Dawson received the M.D. degree at U. of I. College of Medicine and interned in Grand Rapids, Michigan. He is the son of the late Dr. Robert Dawson who practiced in Estherville. . . . **Dr. Walter M. Block,** Cedar Rapids, spoke recently to the Marshall County Child Study Group. His topic, "Effects of TV on Children." . . . **Dr. Gerald Solomons,** professor in the U. of I. Department of Pediatrics, has been elected president-elect of the American Academy for Cerebral Palsy and Developmental Medicine. . . . **Dr. Henry Gurau,** Des Moines, was elected president of the Iowa Academy of Ophthalmology at the Academy's recent annual meeting in Iowa City. **Dr. Russell Watt,** Marshalltown, was chosen president-elect; and **Dr. William Scott,** U. of I. associate professor of ophthalmology, was elected secretary-treasurer. . . . New officers of Iowa Dermatological Society are—**Dr. Robert G. German,** Clinton, president; **Dr. Robert F. Godwin,** Sioux City, vice president; and **Dr. James E. ten Broeke,** Iowa City, secretary-treasurer. Drs. Godwin and ten Broeke are clinical assistant professors in U. of I. Department of Dermatology.

Dr. John Tyrrell, Manchester, and **Dr. Vera French,** Bettendorf, have been appointed by Governor Robert Ray to the new State-wide Health Coordinating Council. . . . **Dr. Harold Miller** joined **Drs. George Gundrum** and **Paul Breckner** in family practice in Burlington in October. A native of Burlington, Dr. Miller received the M.D. degree at U. of I. College of Medicine and took his postgraduate training at Broadlawns Polk County Hospital in Des Moines; University of West Virginia Medical Center in Morgantown, West Virginia; St. Luke's and Mercy Hospitals and Family Medical Center in Davenport. . . . At the annual meeting of the American Academy of Ophthalmology and Otolaryngology, the following U. of I. College of Medicine faculty members were named officers—**Dr. Roger A. Simpson,** second vice president; **Dr. C. M. Kos,** executive secretary-treasurer; **Dr. Frederick C. Blodi,** secretary for ophthalmology; and **Dr. Brian F. McCabe,** secretary for otolaryngology. . . . **Dr. Patricia Ehrich** closed her medical practice in Grundy Center September 30. . . . **Dr. Richard L. Kreiter,** former Clinton physician, has joined Orthopaedic Surgery Associates in Davenport. Dr. Kreiter received the M.D. degree at Columbia University in New York City and completed his orthopaedic residency at University Hospitals in Iowa City.

Dr. Dean M. Harms has assumed the ophthalmology practice of the late Dr. K. S. Sun in Ames. Dr. Harms has been associated with the McFarland Clinic for the past year and a half. A graduate of U. of I. College of Medicine, he interned at Sacramento County Hospital in Sacramento, California and served his residency in ophthalmology at Wisconsin College of Medicine in Milwaukee, Wisconsin. . . . **Dr. Kie Yun Lee,** former Waukon physician, has moved to Webster City. Dr. Lee relocated to be closer to Des Moines where he is president of Des Moines Korean Church.

DEATHS

Dr. C. E. Block, 86, longtime Davenport physician, died September 14 at Ridgecrest Health Wing in Davenport. Dr. Block received the M.D. degree at U. of I. College of Medicine and interned at Montreal General Hospital in Montreal, Canada. Dr. Block had practiced medicine in

Davenport for 57 years, retiring in 1972. He was a past president of the Scott County Medical Society and a life member of the Iowa Medical Society.

Dr. F. A. Gillett, 90, longtime Oskaloosa physician, died September 10 at Mahaska Hospital in Oskaloosa. Dr. Gillett received the M.D. degree at U. of I. College of Medicine and interned at Abbott Hospital in Oskaloosa. He was a past president and life member of the Mahaska County Historical Society, life member of the Surgeons Club of Mayo Clinic at Rochester, Minnesota and life member of the Iowa Medical Society.

Dr. F. B. Leffert, 83, longtime Centerville physician, died September 13 in a traffic accident. Dr. Leffert received the M.D. degree at Rush Medical College in Chicago, Illinois, and began his medical practice in Centerville in 1923. He was a life member of the Iowa Medical Society.

Dr. John F. Sulzbach, 61, former Burlington radiologist, died September 21 at St. John's Hospital in St. Louis, Missouri. Dr. Sulzbach received the M.D. degree at Marquette University College of Medicine, and completed his residency in radiology at University Hospitals in Iowa City. Prior to locating in Missouri, Dr. Sulzbach was a staff member of Radiology Department at St. Francis Hospital in Burlington.

Dr. William F. Brinkman, 90, Pocahontas, died September 11 at the Pocahontas Manor. Dr. Brinkman received the M.D. degree at Rush Medical College in Chicago, Illniois. A practicing physician for 55 years, he began his medical practice in Des Moines and later moved to Pocahontas. He was a life member of the Iowa Medical Society.

Dr. David L. Rater, 79, Ottumwa, died September 27 at St. Joseph Hospital in Ottumwa. Dr. Rater received the M.D. degree at Creighton University School of Medicine in Omaha, and interned at Creighton Memorial and St. Joseph Hospitals. An Ottumwa native, Dr. Rater had practiced medicine in his hometown nearly 48 years, prior to his retirement in 1972.

Dr. Richard L. Waste, 46, Manchester, died of a heart attack on September 22 while attending a medical convention. Dr. Waste received the M.D. degree at U. of I. College of Medicine in 1959. He had practiced in Manchester for the last 15 years. He was a member of the American Academy of Family Practice.

Designed Exclusively for Members of IOWA MEDICAL SOCIETY

Your Group Insurance Program provides:

- Guaranteed-Renewable-Accident and Sickness Disability
- Office Overhead Expense Disability
- Excess Major Medical
- Term Life Plan
- Accidental Death
- Additional Plans

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A Comprehensive Insurance Program Is Important!

Morbidity Report for September

Disease	Sept. 1976	1976 to Date	1975 to Date	Most September Cases Reported From These Counties
Brucellosis	2	14	12	Dubuque
Chickenpox	65	9047	6711	Scattered
Conjunctivitis	47	1535	886	Scattered
Erythema infectiosum	8	162	141	Decatur, Scott
Gastrointestinal viral inf.	1010	17318	16145	Buchanan, Davis, Linn, Pottawattamie
Giardiasis	3	24	20	Johnson, Muscatine
Hepatitis				
A infectious	5	96	128	Black Hawk, Dubuque, Floyd
B serum	3	63	75	Black Hawk, Polk
Unspecified	3	17	25	Butler
Impetigo	89	580	509	Scattered
Infectious mononucleosis	93	782	892	Johnson, Polk, Linn
Meningitis				
aseptic	1	11	8	Marion
due to *E. coli*	1	4	—	Scott
Mumps	50	1245	1065	Black Hawk, Page, Scott
Pediculosis	83	361	258	Muscatine, Scott
Pertussis	2	6	3	Sioux
Pinworms	1	30	35	Polk
Pneumonia	33	767	893	Scott
Rabies in animals	8	106	84	Scattered
Rheumatic fever	1	17	11	Boone
Ringworm, body	22	195	207	Scattered
Roseola fever	2	4	—	Dubuque, Polk
Salmonellosis	10	97	151	Scattered
Scabies	34	479	316	Dubuque, Polk
Shigellosis	8	66	55	Scattered
Streptococcal infections	495	11625	7325	Linn, Johnson, Polk, Scott
Tuberculosis				
total ill	15	85	94	Scattered
bact. positive	13	74	59	Scattered
Venereal diseases:				
Gonorrhea	675	5037	5161	Linn, Polk, Scott, Woodbury
Syphilis	31	252	227	Polk

Laboratory Virus Diagnosis Without Specified Clinical Syndrome
Coxsackie B infection isolated 1, Cytomegalovirus 1, Eaton's Agent inf. 1, Enteropathogenic *E. coli* 1, Herpes simplex isolated 9

LIBRIUM®
(chlordiazepoxide HCl)
5 mg, 10 mg, 25 mg capsules

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Medical Assistants

by BETTY EHLERT, CMA-A

JEANNE GREEN NEW AAMA PRESIDENT-ELECT

Jeanne D. Green, CMA-A, Davenport, was named President-Elect of the American Association of Medical Assistants at the 20th annual meeting in Chicago in September. Mrs. Green, employed by James F. Bishop, M.D., Davenport, President, Iowa Medical Society, has been a dedicated and outstanding AAMA leader. She has served at the local and state levels of AAMA, as well as National Trustee for five years, National Vice President this past year, and on various national committees.

JEANNE GREEN

Other 1976-77 AAMA officers are President—Joan C. Michaels, CMA-A, Charlotte, N.C.; Vice President—Wini B. Schwartz, CMA-AC, Los Angeles, Cal.; Secretary-Treasurer—Dorothy Hartel, CMA-A, Baltimore, Md.; Speaker of the House—Betty Mays, CMA-A, Phoenix, Ariz.; Vice-Speaker—Rita Paris, RT, LVN, CMA-AC, Fort Worth, Texas; Trustees—Doris G. Corey, Lakewood, Colo.; Ann Strobridge, CMA-AC, Oklahoma City, Okla.; Anne Savarese, CMA-AC, Yonkers, N. Y., and Maedelle Sharpton, CMA-C, Tucson, Ariz.

CONVENTION HIGHLIGHTS

Nineteen Iowa Medical Assistants were among the 900 attending the AAMA meeting in Chicago. The program included an exploration of the "Quality of Life" from infancy to old age, a discussion of the pharmaceutical industry and its impact on the practice of medicine, collection procedures, and architectural and emotional barriers for the handicapped.

Roundtable discussions were held within major medical specialties, plus workshops especially for students, leadership training sessions with separate programs for local, state and national leaders. The CMA meeting was devoted to training in the Art of Assertiveness.

Emphasis was on certification and continuing education with a Revalidation Program beginning in 1980, either by examination or accumulation of CEUs. It will be on a voluntary basis in 1980, but medical assistants are urged to keep revalidation in mind in setting up education programs, as CEUs may be counted, beginning in 1977.

A highlight of the convention was the 20th Anniversary Celebration Party, dramatized by skits of the Founding and Charter Meetings and recognition of past national presidents.

IOWA DELEGATES—Iowa's AAMA delegates were, left to right, Mrs. Leanna Rist, CMA-A, Des Moines, Miss Margaret Porter, CMA-AC, Cedar Rapids and Mrs. Nancy Winter, Davenport.

Medical Assistants from Iowa appointed to national committees were Mrs. Charlotte Fell, CMA-A, Des Moines, Education Committee; Mrs. Shirley Muehlenthaler, R.N., Ankeny, Curriculum Review Committee; and Mrs. Betty Ehlert, CMA-A, Des Moines, Public Relations Committee.

The 1977 AAMA annual meeting will be at the St. Francis Hotel in San Francisco October 17-22, 1977.

LIST YOUR WANTS

DOCTORS—THE NEXT MOVE IS YOURS . . . Midwest Medical, Inc. will provide you with more information about each opportunity than you have ever imagined possible. For the first time you can visually preview the Community and Medical Facilities of over 80 opportunities in the Upper Midwest, at ONE location, Saves you time, expense, and frustration. For a thorough appraisal of all factors involved, please accept our invitation to call. For discreet and confidential assistance contact M. A. Cornwall, M.D., MMI's Medical Director, or write: Midwest Medical, Inc., Lakeland, Minnesota 55043. 612/436-5161. Locum Tenens opportunities always available.

WANTED—FAMILY PRACTITIONER to join 8-man multispecialty group. Excellent clinic and hospital facilities. Unusually progressive small community in which to live and raise a family. Excellent salary and benefits, partnership in twelve months, liberal vacation and meeting time. Contact Richard A. Callis, Administrator, McCrary-Rost Clinic, Lake City, Iowa 51449. Telephone 712/464-3194.

WELL ESTABLISHED MEDICAL AND SURGICAL GROUP desires to expand the Family Practice Department from four to six family practitioners. Salary first year—partnership second. No buy-in required. Check this one—it's an excellent opportunity in a good stable economic location with plenty of social, cultural and recreational activities. Contact either G. W. Glenn, Business Manager, or Robert A. Weyhrauch, M.D., 1125 West Fourth Street, Waterloo, Iowa 50702. Phone 319/234-1541.

EQUIPMENT NEEDED—Young family practitioner starting solo practice in 1977 (March 1) interested in purchasing used equipment. Needs include microscope, minor surgical equipment, ECG machine, examining table, also appropriate business machines. Not interested in X-ray equipment. Please contact Don Flory, M.D., Broadlawns-Polk County Hospital, 18th & Hickman, Des Moines 50314; Telephone 515/283-2061.

FAMILY PRACTITIONER WANTED—Two family physicians with large hospital practice wish third associate who is board eligible to join busy family practice. Located in Waterloo, Iowa, a northeast Iowa community of 75,000. All records dictated on the Problem Orientated Medical Records System. Contact Ronald R. Roth, M.D., or Ronald D. Flory, M.D., 611 Black's Bldg., Waterloo, Iowa 50703.

OB-GYN, PEDIATRIC SPECIALISTS needed by 16-man multispecialty clinic in university community of 50,000 in western Wisconsin; excellent retirement and fringe benefits; fine recreational opportunities; salary negotiable. Send curriculum vitae and references to: John R. Ujda, M.D., LaCrosse Clinic, 212 South 11th Street, LaCrosse, Wisconsin 54601.

FOR SALE—well established dermatological practice, equipment and patient's records. Illness—reason for selling. Contact Herbert C. Leiter, M.D., 531 Badgerow Building, Sioux City, Iowa 51101. Phone 712/255-3585.

IOWA PHARMACIST—28 years old, married, two children, would like to locate in small Iowa town presently without a pharmacy or in need of another one. 1971 U. of I. graduate with five years managerial experience in professional (60% Rx) store, and four years consultant experience with two nursing homes (80 beds). Will develop a high quality, professional operation only. Will purchase physician's existing inventory if desired References available on request. Phone 319/365-6736 COLLECT or write No. 1518, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

FAMILY PRACTITIONER WANTED—to join 6-man group. Nicest city in Iowa. New hospital. Well established group. Production contract. Short time to full partnership. Contact Ed Murphy, Carroll Medical Center, 502 North Court, Carroll, Iowa 51401. Phone 712/792-1500.

OBSTETRICIAN to associate with Ob-Gyn Department of established multi-specialty group in St. Paul-Minneapolis and suburban areas. Excellent salary, generous fringe benefits. Tremendous growth potential in one of America's leading metropolitan areas. Curriculum vitae and references invited. Write Box 80100, St. Paul, Minnesota 55108.

PSYCHIATRIC RESIDENCY—Vacancies for positions for July 1, 1977 for those who have a regular Iowa license or can obtain one by reciprocity or via the FLEX. Prepare for career in private practice, community clinics or hospital based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, Children's Unit, Adolescent Unit. Neurology affiliation with University of Iowa. The stipends are: 1st year, $21,294; 2nd year, $22,360; 3rd year, $23,478. Intensity and diversity of training program appreciated best by personal visit. Contact T. B. McManus, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa 51012. Equal Opportunity Employer. Call Collect 712/225-2594.

FOR SALE—Medco Dublett Machine—Model 70, 4½ years old, excellent condition. $350. Contact Steven G. Kruse, M.D., Ballard Medical Center, P.C., 602 North Main, Huxley, Iowa 50124. Phone 515/597-2600.

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respond to one

According to her major
ıptoms, she is a psychoneu-
c patient with severe
iety. But according to the
cription she gives of her
ings, part of the problem
/ sound like depression.
s is because her problem,
ough primarily one of ex-
ive anxiety, is often accom-
ied by depressive symptom-
ogy. Valium (diazepam)
provide relief for both—as
excessive anxiety is re-
ed, the depressive symp-
s associated with it are also
n relieved.

There are other advan-
s in using Valium for the
ıagement of psychoneu-
c anxiety with secondary
ressive symptoms: the
hotherapeutic effect of
um is pronounced and
d. This means that im-
vement is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam) ℞

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

eillance because of their predisposi-
to habituation and dependence.
lsage in Pregnancy: Use of minor
ranquilizers during first trimester
hould almost always be avoided
ecause of increased risk of con-
enital malformations as suggested
ı several studies. Consider pos-
ibility of pregnancy when institut-
ıg therapy; advise patients to
iscuss therapy if they intend to or
o become pregnant.
autions: If combined with other psy-
ropics or anticonvulsants, consider
fully pharmacology of agents em-
ployed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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President's Page

Ponder for a moment, if you will, upon a subject of concern which draws and deserves growing attention, the impaired physician. It is tragic when anyone relinquishes authority over his life and his actions to a chemical whether it be the juice of the grape, the juice of the poppy, or one of man's creations. When that someone is a physician, the waste and the danger somehow seem greater. He —and I will risk the feminists' ire by using the impersonal "he" for both sexes—with his interest in human ailments and his training represents a great investment in time and money by himself and by society. Aside from his value to his family, he is a community resource worth very much effort to maintain or restore. Impaired, he is a constant danger to his patients and a disaster to his family.

The physician who is impaired by alcohol, other drugs, or emotional crippling must be recognized promptly and not protected by family, friends, and colleagues. He must be identified, not for punishment, but for help with his problem, his family, and his patients.

The IMS, its Auxiliary, and the Board of Medical Examiners have been in correspondence and have exchanged their pledges to work together on this problem. The IMS offers the wide-ranging expertise among its members, the Auxiliary offers the sorority of the wives, and the Board all its help in rehabilitation.

Family, friends, patients, colleagues of the impaired physician, tell one of these groups about him. You will not be a stool pigeon—you may be a savior.

James F. Bishop, M.D.

James F. Bishop, M.D., President

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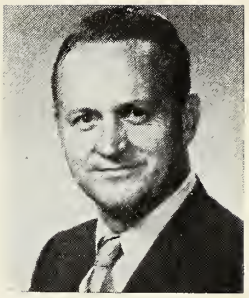
The Question Box



by HERBERT L. NELSON, M.D.

MENTAL HEALTH IN IOWA

Dr. Nelson is Director of the Iowa Mental Health Authority. He is also a professor in the University of Iowa Department of Psychiatry. He serves additionally as chairman of the IMS Committee on Psychiatric Care.

Are mental health services reasonably accessible to all Iowans?

Though the four Mental Health Institutes and the State Psychiatric Hospital are available to all Iowans, they are relatively inaccessible to some because of distance. However, 18 general hospitals have separate psychiatric units. The 33 community mental health centers are available to over 90% of the population, with most of the unserved counties being in the more rural western half of the State. Unfortunately, western Iowa suffers a similar dearth of private care since psychiatrists locate primarily in the larger cities, namely Sioux City, Fort Dodge, Council Bluffs and Des Moines. Eastern Iowa fares much better with 12 communities having psychiatrists in private practice.

Is the mix of care represented by private practice, community mental health clinics, and the state mental health institutes a good one?

Except for the previously mentioned maldistribution, I personally feel the mix of private and public services is good. The Mental Health Institutes provide services that, to date, are not available in many communities. Similarly, the community mental health centers have been developed to meet needs which have not been met by the Institutes or the private sector. More than 50% of those served by centers seek help with family problems and situational reactions not requiring hospitalization or the care of a psychiatrist.

Currently, there are approximately 70 psychiatrists in private practice in Iowa, about 35 of whom work part-time in mental health centers. The other 90 psychiatrists are employed full-time in federal, state and county facilities (State institutions—40, State Psychiatric Hospital—18, Veterans' Hospitals—19, County facilities—10). Also providing considerable services are about 45 psychiatric residents in training in Iowa City, Cherokee and Independence.

How do the Mental Health Authority and the State Psychiatric Hospital fit into the picture?

Everyone, of course, is familiar with the role of the State Psychiatric Hospital as a tertiary psychiatric care center and as a training facility for all the mental health disciplines, particularly psychiatrists. In the past five years there has been a much greater emphasis on research in the Department of Psychiatry and at the same time a steadily increasing hospital admission rate with a shorter average length of stay. The Department welcomes referrals from throughout the State and makes every effort to accommodate appropriate requests for admission.

With guidance from the State Mental Hygiene Committee, the Mental Health Authority has traditionally fostered the development of locally financed and controlled community mental health centers and provided them with professional consultation, continuing education, and assistance in planning and recruitment. The Authority also

(Please turn to page 493)

State Department of Health

Criteria and Techniques for the Diagnosis of Early Syphilis—Revised Recommended Treatment Schedules

Since the advent of penicillin therapy recommendations for the management and treatment of syphilis patients have undergone minimal changes, the last occurring in 1968.

The Center for Disease Control has recently published for the first time "Criteria and Techniques for the Diagnosis of Early Syphilis" and revised the recommended treatment schedules.

Because early syphilis is relatively uncommon in Iowa, the need for reliable and current reference information on the subject is especially important to the physician when the infection is suspected or diagnosed.

The State Department of Health is pleased to provide these important reference materials. Additional information and consultation on sexually transmitted diseases is available by calling (515) 281-3031. Collect calls are accepted.

DIAGNOSTIC CRITERIA/EARLY SYPHILIS

Primary Syphilis

The typical chancre of primary syphilis is solitary, indurated and painless, with a smooth base. Since atypical lesions are common, all genital lesions and suspicious extragenital lesions should be examined for *Treponema pallidum*. The diagnosis of primary syphilis is definite if *Treponema pallidum* is demonstrated by darkfield microscopy or by fluorescent antibody (FA) techniques. (Commensal spirochetes of the oropharynx may be mistaken for *T. pallidum;* therefore, caution must be used in interpreting specimens from this site.)

Failure to demonstrate *T. pallidum* cannot exclude the possibility of syphilis since sufficient organisms may not be present, particularly if topical or systemic antimicrobials are being used. Repeated examinations or aspiration of enlarged regional lymph nodes may be necessary to demonstrate the organism in some patients.

A reagin test for syphilis (such as a VDRL or RPR) should be obtained at a patient's initial visit. Patients with typical lesions and a reactive reagin test should be treated for primary syphilis even if direct examinations for spirochetes are negative. Treponemal serological tests are not recommended in the presence of a nonreactive reagin test regardless of the nature of the lesion. If the initial reagin test is nonreactive, repeat reagin tests should be performed one week, one month, and three months later. Nonreactive reagin tests over three months exclude syphilis as the cause of such lesions.

Secondary Syphilis

Patients with secondary syphilis may present with highly variable skin lesions (usually bilaterally symmetrical macular, papular or papulosquamous), mucous membrane lesions, lymphadenopathy, fever, alopecia or local organ involvement (e.g., iritis, hepatitis or meningitis). Demonstration of *T. pallidum* in material from lesions or lymph nodes in such patients provides proof of syphilitic infection.

A reagin test for syphilis should be obtained from all patients suspected of having secondary syphilis. Patients are considered to have secondary syphilis if they have consistent signs and a reactive serological test even if direct tests for spirochetes are negative or omitted. Patients with

atypical findings or VDRL titer less than 1:16 should have repeat reagin tests and a treponemal test to confirm syphilitic infection. Virtually all patients with secondary syphilis have reactive reagin tests. [One to two percent of such patients will have a nonreactive "rough" or weakly reactive reagin test because of antibody excess, but these sera are reactive upon dilution (the "prozone phenomenon").] Therefore, the diagnosis of secondary syphilis is extremely unlikely if a reagin test for syphilis is nonreactive. Follow-up tests are unnecessary.

Latent Syphilis

In the absence of clinical and historical findings (including anorectal examination in homosexual males and speculum examination in females), patients with reactive reagin and treponemal tests have latent syphilis.

If the serological tests are known to have been nonreactive within the previous one year, or symptoms highly suggestive of primary or secondary syphilis were present during that time, the diagnosis is early latent syphilis. Other patients are considered to have late latent syphilis, and should be evaluated for potential asymptomatic neurosyphilis.

Patients Previously Treated for Syphilis

To establish a new diagnosis of syphilis in patients previously treated for syphilis, either the darkfield exam must be positive or there must be a fourfold increase in the quantitative reagin titer.

Congenital Syphilis

Fetal infection with syphilis is probable if the mother acquires syphilis during pregnancy and remains untreated. Fetal infection may also occur if the mother was inadequately treated for current or previously acquired syphilis. The newborn infected with syphilis may be symptomatic at birth or develop symptoms only later.

Neonates with signs such as skin rashes, nasal discharge, hepatosplenomegaly or sepsis should be suspected of having syphilis. Congenital syphilis is definite if *T. pallidum* is demonstrated by direct examination of material from nasal discharge or skin lesions. Even if direct examinations are negative or omitted, symptomatic neonates with reactive blood tests should receive adequate treatment for syphilis. If the mother has not received adequate treatment for syphilis, congenital syphilis may be considered probable while unknown or uncertain maternal treatment makes congenital syphilis possible, and known adequate maternal treatment makes congenital syphilis very unlikely.

An asymptomatic neonate with reactive serological tests for syphilis may have incubating disease, have been infected but treated *in utero,* or have only passive transfer of maternal antibodies without infection. If the mother has untreated early syphilis, the infant should be evaluated and treated for possible syphilis. Other neonates may be followed without therapy if the parents and physician can ensure careful clinical and serological followup for at least six months.

Cerebrospinal fluid examination to exclude involvement of the central nervous system should be a part of the evaluation of infants with early congenital syphilis.

Late Congenital or Acquired Syphilis

(Discussed in detail in *Syphilis: A Synopsis,* DHEW Publication No. 1660, 1968, Washington, D. C.)

Sex Partners of Patients With Early Syphilis

Sexual partners of patients with primary, secondary or early latent syphilis should be evaluated for symptoms or signs of syphilis and have a reagin test for syphilis. Social contacts of infants with symptomatic neonatal syphilis should be examined in a similar manner.

Therapy is recommended for *all* sex partners of primary, secondary, and those early latent syphilis patients likely to be infectious, since syphilis will develop in 5-30% of the untreated partners.

Followup After Therapy

After treatment, patients with early syphilis should be seen at three-month intervals for at least one year. At each visit, a quantitative reagin test for syphilis should be obtained, and the clinical course reviewed. The reagin titer declines in most patients followed for a year until little or no reaction is detected.

A cerebrospinal fluid examination should be done in those patients who received therapy other than the recommended penicillin regimen.

DIAGNOSTIC TECHNIQUES/EARLY SYPHILIS

Darkfield Microscopy

Obtain material for examination.

Lesions: Clean the surface of the lesion of purulent matter, scab, or epithelium, and gently abrade. From the lesion base, collect serous exudate after it is relatively clear of red blood cells. Use a clean cover glass or slide, or bacteriological

loop or capillary tube to obtain the fluid. Caution: Mouth lesions (mucous patches or chancres) must be well cleansed and walled off completely to prevent contamination by normal oral spirochetes. Even then, the results must be interpreted with care, since these spirochetes may be indistinguishable from *T. pallidum.*

Lymph nodes: When direct examination of skin lesions is negative, and if topical treponemicidal agents have been used, material aspirated from enlarged regional lymph nodes may be diagnostic. Prepare the skin overlying the node and insert a 20-gauge needle into the node. After ensuring the needle tip is within the node, inject a small amount (0.1 ml) of air and saline. Gently manipulate the needle tip to macerate the tissue, and aspirate material to examine for spirochetes.

Examine by Darkfield Microscope. (See *Manual of Tests for Syphilis,* 1969, PHS Publication No. 411, Washington, D. C.)

Fluorescent Antibody (FA) Techniques

Obtain material for examination. Apply a drop of saline to the lesion, mix, transfer to slides and dry. Fix by immersion in acetone for 10 minutes and dry. If slides will not be processed immediately, store at –20 C.

FA technique and interpretation. (See *"Provisional Technique for the Direct Immunofluorescent Identification of* T. pallidum *in Body Fluids and Tissue Section,"* Center for Disease Control, January 1971.)

Cerebrospinal Fluid Examination

Fluid testing. Initial cerebrospinal fluid examinations should include a cell count, determination of the protein concentration, and a VDRL test. The cell count must be done within one or two hours, although specimens for the protein and VDRL tests may be refrigerated for later testing.

Serological Tests

Reagin tests (VDRL Slide, USR, RPR Card and ART tests). The reagin tests, which utilize purified cardiolipin antigens, are recommended for screening purposes because of their reliability and low cost. The reagin titer should always be determined when the test is reactive and a second specimen obtained to verify the reaction. After treatment, the patient should be followed with the same quantitative reagin test since different reagin tests often have significantly different titers.

Treponemal tests (FTA-ABS and MHA-TP tests). The treponemal tests utilize treponemal antigens to detect specific treponemal antibody. These are recommended diagnostic aids for patients with reactive reagin tests who have atypical signs of primary or secondary syphilis (see above), or who have no signs of syphilis. Treponemal tests are also recommended as diagnostic aids for patients with symptoms suggesting late syphilis regardless of reagin tests, since the reagin tests are less sensitive in such cases. Treponemal tests are *not* recommended as screening tests for syphilis or for cerebrospinal fluid testing.

Other Results. Patients with primary syphilis may have one or both of the serologic tests nonreactive when first seen. However, both tests will usually become reactive shortly thereafter. Most patients treated for early syphilis will have reversion of reagin tests to nonreactive within two years. The FTA-ABS test will remain reactive after treatment of early latent, secondary, and most cases of primary syphilis. Nonreactive serologic tests and normal clinical evaluation cannot exclude incubating syphilis.

Borderline reaction in the FTA-ABS test provides no evidence for or against syphilis. Beaded reaction in the FTA-ABS test is most often associated with chronic inflammatory diseases. Repeat testing is indicated in both instances.

Caution. Serologic tests provide only indirect evidence of syphilis and may be reactive in the absence of clinical, historical or epidemiological evidence of syphilis. Therefore, careful clinical interpretation of test results and other evidence is necessary for proper diagnosis.

RECOMMENDED TREATMENT SCHEDULES FOR SYPHILIS

Penicillin continues to be the drug of choice for all stages of syphilis. Every effort should be made to document penicillin allergy before choosing other antibiotics. Physicians are cautioned to use no less than the recommended dosages of antibiotics.

Early syphilis (primary, secondary, latent syphilis of less than one year's duration)

Rx: (1) Benzathine penicillin G—2.4 million units total by intramuscular injection at a single session. Benzathine penicillin G is the drug of choice, because it provides effective treatment in a single visit.

OR:

(2) Aqueous procaine penicillin G—4.8 million

(Please turn to page 492)

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

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PHYSICIAN MANPOWER PICTURE BRIGHTENING

YEAR'S END means inventory-taking for many, a time to look at *plus* and *minus* columns. If we subject primary health care delivery in Iowa to this sort of exercise it's possible to make a number of significant entries on the *plus side.*

Since the turn of the decade Iowa efforts to meet the physician manpower challenge have been in an accelerated position. Much credit is due the positive leadership of the administration of the University of Iowa College of Medicine. The accomplishment includes:

- The University of Iowa College of Medicine has increased its enrollment by 45% in six years. Entering classes now number 175 compared to 120.
- Medical school attrition rates have dropped below 3% which means, with the enrollment hike, there's been a 50% increase in today's graduating class from those of the sixties.
- Parallel with this numerical increase has been the strong emphasis on medical student exposure to primary care. The Department of Family Medicine has emerged while the Departments of Internal Medicine and Pediatrics have expanded.

The emphasis on primary care at the undergraduate medical level has produced a need for internships and residencies in Family Practice, Internal Medicine and Pediatrics. Indicative of this is the 1976 U. of I. medical class: three-fourths of the graduates elected to pursue primary care programs.

Nationwide establishment of residency programs in Family Practice has occurred. There are 300 such programs now, with seven of them in Iowa. These are located in Des Moines (2), Iowa City, Cedar Rapids, Davenport, Mason City and Sioux City. A program in Waterloo is under development.

The Iowa Family Practice Residency Network had its inception in 1972 with the first programs in Cedar Rapids, Iowa City and Des Moines. The network was formalized by legislative action in 1973. It had seven residents in training in 1972. It has 128 this current year. When fully operative, the network will have a capacity for between 160 and 170 residents with more than 50 finishing each year.

Is the program bearing fruit?

The first sizable class of residents completed the three-year program this year. Fifteen of the 24 (or 62%) remained to practice in Iowa. Of these, 10 have located in towns of 9,000 or less. The communities (and population) are:

Centerville (6,531)
Cresco (3,927)
Fairfield (8,715)
Fredericksburg (2) (912)
Glenwood (4,421)
Lone Tree (824)
Osage (8,815)
Waukon (3,883)
Webster City (8,488)

The Iowa Family Practice Residency Network receives financing from various sources. For 1976-77, in addition to funds from the University of Iowa budget, support is allocated on the following basis: federal grants—$670,000; state grants—$815,000; community hospital & service support—$3,337,792. When totally operative the statewide system is expected to cost over $6.5 million a year.

Progress has also been made in assisting Iowa communities of lesser population. Different forms of service are being tried to see how effective they are and how well they are accepted by the public. Involved here are:

1. Satellite offices manned by family nurse practitioners or physician's assistants.
2. Intermittent physician visitation to a satellite.
3. Improved patient transportation between a regional primary care center and the satellite.

Experimentation to date has produced mostly good vibrations. The several new community health care delivery models (Muscatine Community Health Center, Red Oak Regional Primary Care Center) are drawing praiseworthy reactions.

It's heartening to see these developments. They are worthy of note by all concerned Iowans. It's significant that we have 85 more physicians practicing in Iowa than five years ago and suggests we have made a crucial turnaround.

A continued commitment—financial and otherwise—is needed if the progress is to be ongoing. This support must come from the University, the medical profession, the federal and state governments, the other health care providers and the public in general.

IN THE PUBLIC INTEREST

SCIENTIFIC ARTICLES

Antepartum Prevention Of Respiratory Distress Syndrome

(Hyaline Membrane Disease)

SAHEB SAHU, M.D.
Des Moines, Iowa

Both animal and human studies have shown convincingly that antepartum use of steroid accelerates pulmonary maturity by stimulating surfactant synthesis. The mechanism of steroid action, method of its use and its effects in preventing respiratory distress syndrome is described.

IT HAS BEEN ESTIMATED a minimum of 40,000 babies suffer from respiratory distress syndrome (Hyaline Membrane Disease) per year in this country. The disease claims at least 10,000 lives per year[1, 2] (10,897 out of total neonatal deaths of 56,456 or 19.3% of neonatal deaths). The overall national mortality rate from RDS* is about 28%. It accounts for 50 to 70% of premature deaths. Although intensive neonatal care, correction of metabolic imbalance, continuous positive airway pressure, and assisted ventilation have contributed to a great reduction in mortality, still the present high rate is unacceptable. Unfortunately, all the modern modalities of therapy are directed toward cure of the disease but not the prevention. Recently, corticosteroid has been used successfully in preventing the disease.[3] This article is an attempt to review the available materials in the use of steroid to prevent RDS.

* RDS = Respiratory distress syndrome or hyaline membrane disease.

The author is Director of Nurseries at Mercy Hospital, Des Moines, Iowa. He is also assistant professor of pediatrics at the College of Osteopathic Medicine and Surgery.

ETIOLOGY OF RDS

Various factors like perinatal asphyxia, maternal diabetes, toxemia, cesarean section, maternal hemorrhage and prematurity have been blamed for causing hyaline membrane disease. However, firm evidence implicates the following as predisposing, or aggravating, insults: (1) prematurity,[4, 5] shorter gestation generally implies greater severity; (2) perinatal asphyxia;[6, 7] (3) cesarean section.[8, 9] More fundamentally, however, RDS seems to reflect the failure of the developing lung to produce surface-active material, specifically highly saturated lecithins, in quanti-

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF DECEMBER, 1976.

ties adequate either to establish a normal preterm concentration ("reservoir") or to meet the postnatal demands of constant consumption. It may be reasonably postulated that RDS occurs as consequence of the relative inability of the lung to synthesize surfactant in amounts sufficient for neonatal respiratory adaptation.

Pathogenesis

The presence of adequate amounts of surface-active material to line airspaces is one of the prerequisites for adequate postnatal pulmonary adaptation. The surface-active material (surfactant) reduces the surface tension, maintains alveolar stability at low pressures so that on end-expiration, alveolar collapse does not occur. Surface-active material must not only be present in adequate amounts at birth but also must be regenerated at a rate consonant with its disappearance. This implies functionally intact and viable Type II alveolar cells (which are producers of surfactant). The surfactant consists of lipids, mainly lecithin (50 to 70%), proteins and carbohydrates.

Biosynthesis of Surface-Active-Lecithin

There are two enzymatic pathways for lecithin synthesis.[10]

Pathway I—Phosphocholine (Cytidyl) Transferase

It is the major pathway for biosynthesis of lecithin in human lungs where there is a transfer of choline phosphate to diglyceride in the presence of cytidine-phosphate as co-enzyme. Generally, in mammalian orders below primates, this is the only effective pathway for the synthesis of lecithin once the fetus begins to breathe. In man, this pathway matures at about 35 weeks of gestation, at which time it can be said that the lung is biochemically mature.

Pathway II—Methyltransferase

In this pathway, methionine is utilized as methyl donor in the presence of ATP (S—adenosyl, L—methionine), which are transferred to phosphatidylethanolamine. This pathway is first detectable at 22-24 weeks of gestation in humans, but continues to increase in activity for lecithin synthesis and contributes up to 50% of the surface-active alveolar lining lecithin at term and there after. *Synthesis of lecithin by this pathway is adversely affected by acidosis, hypothermia and hypoxia.* This pathway permits human beings to be born and survive as premature infants.

Type II—Pulmonary Epithelial Cells

Investigation has shown that without much question the source of surfactant synthesis and secretion is the Type II epithelial cell of the alveolus, also known as niche cells or granular pneumocytes.[11] The Type II cells contain not only the requisite organelles (mitochondria, endoplasmic reticulum, Golgi bodies) but also the enzymes necessary for the synthesis of lipids. Animal experiments have shown that appearance of surfactant coincides with the differentiation of Type II alveolar cells and with the presence of certain organelles (which stain readily when exposed to osmic acid) within the Type II cell cytoplasm. These cytoplasmic inclusions are referred to as osmiophilic bodies and they primarily contain phospholipid material.[12] If surfactant is absent in the alveolar tissue, osmiophilic bodies are found to be absent or very few in number, suggesting that they are organelles which store the surfactant after it is synthesized by Type II cells.[11] Electronmicroscopic examination of the lung has demonstrated extrusion of the contents of these inclusion bodies into the alveolar space.[12]

In human fetuses, osmiophilic bodies may appear in small numbers as early as the 20th week of gestation. The bodies are usually present after 26 weeks, corresponding closely to the time when surfactant is first found in the fetal lung.[13] In preterm infants who die of RDS soon after birth, the Type II cell cytoplasm contain few, if any, osmiophilic bodies.[11]

The Lecithin/Sphingomyelin (L/S) Ratio

The fetal lung secretes fluid containing surfactant which rises into the posterior pharynx. Most of this is swallowed but an unknown fraction enters the amniotic fluid. The ratio of lecithin and sphingomyelin (L/S ratio) is easily determined, is independent of amniotic fluid volume, and is specific in predicting maturity of fetal lung.[10] A L/S ratio of 2 or greater indicates a mature lung and is seldom associated with respiratory distress syndrome (less than 1% of cases, 5 out of 1,140 samples). Authorities agree that a positive "shake test" (stable foam at 1.2 dilution) is quite reliable and correlates well with the L/S ratio.[2] However, negative shake test, as with low L/S ratios less than 2, are of less predictive value.

Factors Accelerating Pulmonary Maturity[14]

(1) Small placenta with multiple infarctions, excessive fibrinous degeneration, and small umbilical cord.

(2) Retroplacental bleeding and circumvallate placenta.

(3) Maternal conditions such as hypertension resulting from severe toxemia, renal disease, or cardiovascular disease; and diabetes mellitus (classes DEF).

(4) Sickle—C—disease.

(5) Narcotic addiction.

(6) Pharmacologic agents—steroids, heroine, thyroxine.

Bauer, *et al.*, reported decreased incidence of RDS associated with prolonged rupture of membranes.[15] They found significantly elevated corticosteroid levels in both infants and mothers (with prolonged rupture of membrane) and postulated that these elevated corticosteroids may be the agents for accelerating lung maturation. Recently, Jones, *et al.*, have disputed these findings.[8]

Factors Delaying Maturation of Fetal Lung[14]

(1) Diabetes Mellitus (classes ABC).

(2) Chronic nonhypertensive glomerulonephritis.

(3) Certain cases of hydrops fetalis.

In the above conditions maturation of L/S ratio may not occur until 37 weeks of gestation.

Use of Steroid for Accelerating Pulmonary Maturity

Liggins, in 1969, noted that lambs delivered prematurely at 118 to 123 (term is 147 days) days after intrafetal infusions of ACTH, cortisone, or dexamethasone were viable and that, when sacrificed, their lungs remained partially expanded.[16] Delemos, *et al.*, confirmed Liggin's observations by comparing the lungs of cortisone-treated fetal lambs with those of their untreated twins.[17] They found in all animals of more than 100 days of gestation that the lungs of treated lambs had functional evidence of accelerated appearance of surfactant.

Wang, *et al.*, demonstrated increased formation of osmiophilic bodies in Type II alveolar cells and abundant osmiophilic material in the alveolar spaces of steroids treated rabbit fetuses.[18]

Naeye, *et al.*, in a study of 387 necropsies on human neonates dying within 72 hours of birth, showed the mean weight of adrenal glands was 19% lower in neonates dying with hyaline membrane disease than in those free of the disorder. In addition, they found that anencephalic neonates with hypoplastic adrenal cortices had, in comparison with neonates without this malformation, less than half the mass of osmiophilic granules in Type II alveolar cells.[19]

Possible Mechanism of Steroid Action

Corticosteroid easily crosses the placental barrier. A high concentration of glucocorticoid receptors has been identified in the cytoplasm and nuclei of fetal lung.[20] Present evidence suggests that corticosteroids induce de novo synthesis of lung enzyme, which in turn leads to increased synthesis of lecithin through the choline incorporation pathway.[21] It seems likely that cortisol has a physiological function in regulating lung maturation in certain species, since hypophysectomy may lead to delay in lung maturation which is preventable by administering corticotrophin or dexamethasone.[22] A significant rate of rise in L/S ratio has been demonstrated in women (between 28-32 weeks of gestation) receiving glucocorticoid (dexamethosone) treatment.[23]

Antepartum Use of Glucocorticoid to Prevent RDS

Postnatal use of corticosteroid does not prevent RDS.[24] Liggins and Howie (New Zealand) started using corticosteroid in mothers with premature labor (before 37 weeks) in 1969, and published their results first in 1972 and subsequently in 1974.[3, 25] At present, they are considered the best authorities in the field.

Methods[3, 25]

Dr. Liggins' trial was designed on a double blind basis, the ampules of material for injection being indistinguishable from each other, arranged in random order and numbered serially. Two groups of patients were included in the trial. The first group (unplanned deliveries) comprised women admitted to the hospital at 24-36 weeks of pregnancy in which a diagnosis of premature labor was made. The second group (planned deliveries) comprised women who were to be electively delivered before 36 weeks of pregnancy because of complications such as hypertension or hemolytic disease.

On admission to the trial, each patient was given an intramuscular injection of the material contained in a numbered vial. The vials contained either a mixture of 6 mg betamethasone phosphate and 6 mg betamethasone acetate or a control of identical appearance consisting of 6 mg cortisone acetate (as placebo), the latter's glucocorticoid potency being approximately one-seventieth that of the betamethasone preparation. Unless delivery had already occurred, an injection of the same material was repeated 24 hours later. Attempts were made to delay delivery 48-72 hours from the time of first injection

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Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

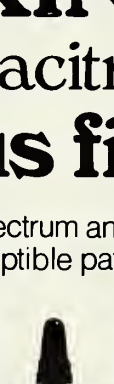

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TABLE 1[25]

EFFECTS OF ANTEPARTUM ADMINISTRATION OF STEROIDS ON UNPLANNED PREMATURE LABOR

	Betamethasone Treated Group (289 Babies)	*Control Group (266 Babies)*	*P*-Value*
Perinatal deaths	10.4	17.7	0.03
RDS			
a. All gestational age > 37 wks.	8.7	26.3	
b. Age 26 < 32 wks.	*21.2*	*63.2*	0.01
c. 32 < 37 wks.	3.8	3.3	
Intraventricular hemorrhage	1.7	11.1	0.01

* P-values were derived by using the chi-squared test with Yates' correction. P > 0.1 = not significant.

with the use of IV ethanol or salbutamol. After delivery, infants were evaluated both clinically and radiologically (one radiologist) for the presence of RDS. Histological sections from necropsies on infants who died were reviewed by one pathologist. A total of 289 babies in betamethasone-treated group and 266 babies in the control group were studied.

RESULTS

Unplanned Premature Delivery

Overall, infant survival is shown in Table 1. Perinatal deaths were reduced from 17.7% in the control group to 10.4% in the treated group. This resulted entirely from a reduction in early neonatal deaths in the treated group, attributable mainly to a reduced incidence of RDS (8.7% in treated group compared to 26.3% among control), but also to fewer cases of intraventricular hemorrhage (1.7% compared to 11.1% among controls). The best result was obtained in babies of under 32 weeks gestation who had been treated for at least 24 hours before delivery (RDS incidence of 21.2% among the betamethasone-treated babies compared with 63.2% among the controls). There was no increased incidence of premature labor, growth retardation, lowered resistance to infection, adrenal insufficiency, hypoglycemia or hyperbilirubinemia among betamethasone treated infants over controls.[25]

Planned Premature Delivery

Only 34 infants received betamethasone under planned premature delivery (after planned induction of labor or elective cesarean section). The overall perinatal mortality of the treated group was 35.3% compared with 16% in the control group. However, this difference was not statistically significant (P > 0.1).

Double Dose of Betamethasone

Liggins used double dose of betamethasone (24 mg at the time of admission and 24 mg 24 hours later) but found no evidence of a dose-related response in the incidence of RDS in unplanned premature births (overall, 11.4% compared to 22.5% in controls).[25]

Contraindications for Use of Betamethasone

Severe hypertensive complications of pregnancy.

DISCUSSION

Despite progress in understanding and treating respiratory distress syndrome, it remains the leading cause of death among neonates. Firm evidence exists that prematurity (associated with deficiency of surfactant), perinatal asphyxia (inhibit surfactant synthesis), and cesarean section predispose a baby to RDS. Perinatal asphyxia can be prevented by adequate monitoring of all the mothers, early detection of fetal distress and taking proper measures to correct them, judicious use of analgesia and anesthesia and prompt, and adequate resuscitation of a asphyxiated neonate.

Many of the iatrogenic causes of prematurity would be prevented if, (a) estimation of fetal maturity (pulmonary, too) is based not only on expected dates of confinement but also on other available parameters; (b) induction of labor or cesarean section is not done unless there is a definite medical indication for it.

More routine use of fetal monitoring will reduce rate of cesarean section just for tachycardia or bradycardia by pin-pointing real *signs* of fetal distress. Use of amniocentesis and estimation of L/S ratio or shake test will give indication of degree of pulmonary maturity and will help to decide the time of induction or cesarean section in high-risk pregnancies.

Surfactant is synthesized and stored in Type II cells (pneumocytes) of the alveolus. Both animal and human studies have shown clearly that when corticoid is given to the pregnant mother, it crosses the placenta easily and stimulates the synthesis of surfactant by the choline incorporation pathway. From all the studies available, it appears that rules of evidence have been properly satisfied with regard to the appropriateness and efficacy of glucocorticoids in prevention of RDS (Liggins).[25] Because of this, and because of some

instances, the anticipated benefits clearly outweigh the hypothetical risks, antenatal administration of glucocorticoid should be considered—

(1) In pregnancies, where the infant must be delivered before 32 weeks of gestation.

(2) The amniotic fluid shows an immature L/S ratio.

(3) The delivery can be safely deferred at least 24 hours.

The long-term effects of steroid treatment on the fetus still require evaluation. The glucocorticoid which may prove to be the most effective therapeutic agent and its dose, duration of treatment and other possible adverse effects remain to be worked out. Administration of high doses of steroids is recognized to be associated with increased incidence of gastrointestinal ulceration and hemorrhage. Recently, two cases of upper gastrointestinal bleeding in women receiving betamethasone treatment have been reported.[26] However, most of the authorities (Avery, James, Tooley, etc.) feel the benefits of glucocorticoids administration far outweigh the potential risk; use of betamethasone should no more be considered experimental, and be used in all mothers when they meet the proper criteria.

The potential benefit of thyroxin as an early inducer of early lung maturity is under investigation. There is much yet to be learned about the respiratory distress syndrome. Advances in recent years have been numerous (use of CPAP, steroid, etc.) and the findings extremely encouraging. With further investigation and understanding, it may be that respiratory distress syndrome could become a preventable disorder.

REFERENCES

The references noted in this article are available either from the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

My acknowledgements to Niki Conrad for typing this paper.

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1975 Iowa High School Football Play-Off Series

PETER D. WIRTZ, M.D.
Des Moines

The playing of three high school football games in 10 days was questioned from the injury prevalence standpoint. Findings from a study show the incidence of injuries indicate the early concern was unfounded.

In 1975 there was considerable concern expressed among the members of the Iowa Medical Society Committee on Sports Medicine over the possibility of excessive injuries during the Iowa high school play-off series due to the short time interval between the scheduled games. It has been reported in sports journals that the injury rate increased in Illinois when the play-off series was scheduled on a Saturday-Wednesday-Saturday basis. The following is a summary of the 1975 Iowa high school football play-off series.

In the play-off series the 32 competing teams were required to survey those player injuries (a) requiring medical attention, and (b) those not requiring medical attention. A summary of the survey was compiled by the Iowa High School Athletic Association and shows that in the first round games, involving 32 teams, the majority of the problems (nine) included injuries to the knee and sprains of various joints. There was one ankle injury that required surgery and one fractured fifth metacarpal bone which required medical management. One concussion and two leg injuries were evaluated and produced no complication. In the semi-final games, in which 16 teams competed, there was one shoulder separation; one knee injury that required surgery; one finger and one thumb fracture that required medical management. In addition, there was one concussion and one severe bruise and one case of hyperventilation. In the final games, in which eight teams competed, there were two sprains and one knee injury that required medical attention, as well as one further hand injury.

In the same series of games those injuries that did not require medical attention included six sprains in the first round games, three sprains in the semi-final game, and one sprain in the final game.

A total of 34 injuries out of 1,232 participants is an overall 2.7 percent injury rate.

In the first round games, 15 of the 18 total injuries were sprains; 18 of 704 participants is a 2.5 percent incidence of injury. In the semi-final games 11 out of 352 participants had injuries and this is a 3.1 percent incidence. In the final games, 5 injuries occurred among 176 players for a 2.8 percent incidence of injury. These injury rates did not show an expected increase in incidence when the games were scheduled on a Saturday-Wednesday-Saturday basis. There was no specific reference to reinjury of different muscles and sprains but it was generally felt that the sustained injuries were not connected or related to the period of time between the games.

The schedule of play-off games which is followed does not seem to suggest a need for change because of injuries. Those participating schools expressed a strong desire to follow the same schedule if they reached the 1976 play-offs. The Iowa High School Athletic Association is to be complimented for this excellent and conscientious review of medical conditions which developed during the 1975 play-off series.

Dr. Wirtz is in the private practice of orthopedic surgery in Des Moines. He is a member of the Iowa Medical Society Committee on Sports Medicine.

Editorials

M. E. ALBERTS, M.D., Scientific Editor

THOUGHTS FOR THE SEASON

It is difficult to develop a Christmas Season message the first week in November. This is true even though the shops and department stores, the mail order outlets, and various opportunists are already busy attempting to entice buyers of their merchandise. The Season must mean more to us than lights, tinsel, wrapping papers and ribbons.

This year the Jewish festival of Hanukkah commences on the eve of December 17 which is the 25th day of Kislev. The eight days of Hanukkah thus end on December 25. The ritual of the lighting of candles for eight days commemorates the deliverance of the Maccabees from their Syrian and Greek oppressors. Though this is considered a minor festival on the Jewish calendar, it represents a freedom in the lives of the Jews. Christians in celebrating the birth of Christ also commemorate a new birth—the coming of a Savior.

As we come to the end of another 12 months, and face a New Year, we must look at ourselves and about us and be alert to what we may observe. When the excitement of the holidays is over, and the trappings of the Season are put away, it becomes necessary to check the ledger pages. I do not refer to the cash ledger reflecting the bills owed for gifts; instead the ledger reflecting the assets and liabilities of our lives. Society must measure these as a whole, and each person must do so in an individual manner.

During the late 1700's an English poet and artist, William Blake, wrote his "Songs of Innocence and of Experience." These beautifully illustrated works of art were his way of showing the two contrary states of the human soul. One of his poems entitled "The Human Abstract" has a stanza which provides much to reflect on. Blake depicts religion as a tree—a tree that nature does not recognize. This tree has grown from experience, or the reasoning powers of the human mind. False virtues arise from selfishness, fear and weakness. Blake expresses it thus:

> *The Gods of the earth and sea,*
> *Sought thro' Nature to find this Tree*
> *But their search was all in vain;*
> *There grows one in the Human Brain.*

The entire poem develops into a statement of true faith in the divinity of unrepressed human instincts and the holiness of life.

At this Season, then, let us reflect on life and all the beautiful works of nature around us. As the New Year is ushered into being we will face new problems—the hard realities of politics, a new administration, taxes, the economy and such other problems of life. For the moment we shall pause and utter a prayer similar to the Jewish prayer on viewing the beauty of nature:

Praised are You, O Lord our God, King of the universe, who has fashioned such beauty in this world.

Shalom aleichem and Merry Christmas, and Happy New Year!—M.E.A.

SONS OF "DES" MOTHERS HAVE UROLOGICAL PROBLEMS

The sons of mothers who took diethylstilbestrol (DES) during pregnancy have increased rates of urogenital disease, a team of researchers from the University of Southern California reports in the October issue of PEDIATRICS, the monthly scientific journal of the American Academy of Pediatrics.

For several years, scientists have been investigating the high rate of vaginal cancer in daughters of women who took DES during their pregnancies to prevent miscarriages. Now, the USC team says sons of these same mothers apparently suffer various urogenital tract anomalies.

The researchers located male offspring who were exposed to DES, surveyed them by mail, and compared their responses to a group of unexposed men born in the same period and receiving the same general medical care.

Result? The researchers said that both groups had similar medical histories with one notable exception—DES-exposed men had experienced significantly more problems passing urine, and suffered significantly more urogenital abnormalities.

"There was no difference between the DES-exposed and DES-unexposed males in the frequency of a history of heart disease, diabetes, asthma, hay fever, childhood infectious diseases, appendectomy, or tonsillectomy," the researchers reported. "However, the DES-exposed males did report a significant excess experience with disease of the urogenital tract."

In fact, 12.9% of the exposed men reported problems passing urine, while only 1.8% of the unexposed men had experienced such difficulty. The most common problem reported by the exposed men was urethral stenosis.

"We believe it very possible that *in utero* DES exposure is related to urogenital tract anomalies in sons," the PEDIATRICS report concluded. "While the most characteristic anomaly seems to be urethral stenosis, there may be an association between DES exposure and a variety of urinary tract anomalies. The findings suggest that more detailed historical and clinical examination of such boys is warranted."

Authors of the report are Brian E. Henderson, M.D., Barbara Benton, R.N., Malcolm Cosgrove, M.D., Joyce Baptista, M.A., James Aldrich, M.S., Duane Townsend, M.D., William Hart, M.D., and Thomas M. Mack, M.D.

MORE ABOUT DES

The National Cancer Institute's Division of Cancer Control and Rehabilitation is directing a study (called the DESAD project) which deals with diethylstilbestrol-associated vaginal and cervical irregularities and the rare instances of clear-cell adenocarcinoma that occur in DES-exposed daughters.

A pamphlet has been compiled by the DESAD Project to provide information that is important to every physician who is likely to be contacted concerning DES exposure *in utero*. The pamphlet answers questions physicians and patients may have in mind, such questions as: What is DES? Why were DES-type drugs used in pregnancy? What is the cancer problem associated with *in utero* exposure? What is the management of vaginal and cervical irregularities other than clear cell adenocarcinoma?

This *Information for Physicians* pamphlet is available at no cost from the National Cancer Institute's Office of Cancer Communications, Dept. IA, Bldg. 31, Room 10A19, Bethesda, Maryland 20014. Two other publications on this subject—*Questions and Answers About DES Exposure Before Birth* and *Were YOU or YOUR DAUGHTER Born After 1940?* These may be ordered in quantity, without charge, from the same office.

HONOR DON TAYLOR

Donald L. Taylor, now retired after a long career as executive vice president of the Iowa Medical Society, was recognized recently for outstanding service to the American Medical Association. The plaque/citation honored Mr. Taylor for 1969-1973 membership on the AAMSE Advisory Committee to the AMA executive vice president. AAMSE is the American Association of Medical Society Executives.

Educationally Speaking

by RICHARD M. CAPLAN, M.D.

THE HUMANITIES—WHY AND HOW

Maybe I sometimes reflect on the humanities and what they're about just because I live and work in the midst of a major university. But whatever the reason, I've come to feel that the humanities have an important role to serve in the lives of physicians—not just because they are or ought to be generally educated, sensitive and thoughtful citizens, but even more because the humanities should be serving us in our roles *as physicians.*

Perhaps some would think this to be saying, "The humanities will make you more compassionate." Possibly so, but not necessarily. Some might think it says, "Ethical decision making will be easier if you study the humanities." Maybe, but likely not; rather, it will make the nature and origins of the issues and decisions more informed. What then can the humanities do for us? David Callahan, Director of the Institute for Society, Ethics and the Life Sciences, an articulate spokesman (that's one thing the humanities can do—make us more articulate), has stated it this way:

What happens, though, when the humanist does try to move out of the study and the classroom? He runs into something which those in the clinics, legislatures, hospitals and community organizations call the "real world"—a phrase usually employed to knock him down. . . . The only genuinely fruitful strategy is to recognize that what constitutes the "real world" is a question worthy of attention in its own right. It is the one subject about which those from the humanities have something to say. Whether they say it in the language of philosophy, law, literature, or history. The real world is not just composed of facts, nasty clinical decisions, blood in the emergency room. It is no less made up of values, ideas, imagination, theories, dreams, the unconscious—the very stuff of the humanities. Whose blood ends on the emergency room floor may have been as much influenced by Karl Marx or Thomas Jefferson as by the gun that put the person there; and what the physician decides to do about the bleeding person can be traced to theories and moral values having little to do with what he learned about clamping arteries in medical school.

The humanities are not relevant because they can go out and say something useful to physicians. . . . As often as not, they can't. They are only pertinent when they do what they can do—remind people that the real world is a reality even richer and more complex than day-to-day life in the laboratory might suggest. No one field can build or interpret the world. The various disciplines need each other.

Just as I feel that a physician ought to be much more than a narrowly-trained technician, I think a physician's continuing education ought to be much more than narrowly medical. There are loads of opportunities in formats of all sorts. What can be suggested to the physician who thinks he/she already gives all available study time to continuing *medical* education? A tough question, and a fair one. Perhaps it will be useful to begin by understanding a greater breadth to the word *medical.* If nothing else, enlarging what you mean by *medical* should reduce the load of guilt you might feel at giving time to study life as it is refracted through the insights of the humanities.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

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Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

Professional Relations Division, Beltone Electronics Corporation
4201 West Victoria Street, Chicago, Illinois 60646, an American company

Beltone
WHEN A HEARING AID WILL HELP

STATE DEPARTMENT OF HEALTH

(Continued from page 478)

units total: 600,000 units by intramuscular injection daily for 8 days.

Patients who are allergic to penicillin:

Rx: (1) Tetracycline hydrochloride—500 mg four times a day by mouth for 15 days. (Food and some dairy products interfere with absorption. Oral forms of tetracycline should be given one hour before or two hours after meals.)

OR:

(2) Erythromycin (stearate, ethylsuccinate or base)—500 mg four times a day by mouth for 15 days.

These antibiotics appear to be effective, but have been evaluated less extensively than penicillin.

Syphilis of more than one year's duration (latent syphilis of indeterminate or more than one year's duration, cardiovascular, late benign, neurosyphilis)

Rx: (1) Benzathine penicillin G—7.2 million units total: 2.4 million units by intramuscular injection weekly for three successive weeks.

OR:

(2) Aqueous procaine penicillin G—9.0 million units total: 600,000 units by intramuscular injection daily for 15 days.

Patients who are allergic to penicillin:

Rx: (1) Tetracycline hydrochloride—500 mg four times a day by mouth for 30 days. (Food and some dairy products interfere with absorption. Oral forms of tetracycline should be given one hour before or two hours after meals.)

OR:

(2) Erythromycin (stearate, ethylsuccinate or base)—500 mg four times a day by mouth for 30 days.

Cerebrospinal fluid examination is highly recommended before therapy with these regimens.

SYPHILIS IN PREGNANCY

Evaluation of Pregnant Women

All pregnant women should have a nontreponemal serologic test for syphilis, such as the VDRL test, at the time of the first prenatal visit. In women suspected of being at high risk for syphilis, a second nontreponemal test should be performed during the third trimester.

Seroreactive patients should be expeditiously evaluated. This evaluation should include a history and physical examination, as well as a quantitative nontreponemal test and a confirmatory treponemal test.

Rx: (1) For patients at all stages of pregnancy who are not allergic to penicillin: Penicillin in dosage schedules appropriate for the stage of syphilis as recommended for the treatment of nonpregnant patients.

Rx: (2) For patients of all stages of pregnancy who are allergic to penicillin: Erythromycin (stearate, ethylsuccinate or base) in dosage schedules appropriate for the stage of syphilis, as recommended for the treatment of nonpregnant patients.

Erythromycin estolate and tetracycline are not recommended for syphilitic infections in pregnant women because of potential adverse effects on mother and fetus.

Followup

Pregnant women who have been treated for syphilis should have monthly quantitative nontreponemal serologic tests for the remainder of the current pregnancy. Women who show a fourfold rise in titer should be retreated. After delivery, followup is as outlined for nonpregnant patients.

CONGENITAL SYPHILIS

Congenital syphilis may occur if the mother has

INTERPRETATION OF RESULTS

Test Results		
Reagin	*FTA-ABS*	*Interpretation*
Weakly reactive or reactive	Reactive	These results usually indicate syphilis. Tests should always be repeated on a new specimen if doubt exists.
Weakly reactive or reactive	Nonreactive	"Biologic False Positive" (BFP) reaction in reagin tests may be caused by: infections, immunizations, inflammatory disease, immunoglobulin abnormalities, drug addiction, pregnancy or aging. Repeat tests on a new specimen to confirm the BFP, and evaluate for these causes.
Nonreactive	Not Done	Treponemal tests are not indicated unless late syphilis is suspected on clinical grounds. A reactive FTA-ABS test would add weight to the diagnosis of late syphilis.

syphilis during pregnancy. If the mother has received adequate penicillin treatment during pregnancy, the risk to the infant is minimal. However, all infants should be examined carefully at birth and at regular intervals thereafter until nontreponemal serologic tests are negative.

Infected infants are frequently asymptomatic at birth and may be seronegative if the maternal infection occurred late in gestation. Infants should be treated at birth if maternal treatment was inadequate, unknown, with drugs other than penicillin, or if adequate followup of the infant cannot be ensured.

Infants with congenital syphilis should have a CSF examination before treatment.

Infants with normal CSF: Rx: Benzathine penicillin G 50,000 units/kg intramuscularly in a single dose.

If neurosyphilis cannot be excluded, the procaine or crystalline penicillin regimens are recommended. Other antibiotics are not recommended for neonatal congenital syphilis.

Penicillin therapy for congenital syphilis after the neonatal period should be with the same dosages used for neonatal congenital syphilis. For larger children, the total dose of penicillin need not exceed the dosage used in adult syphilis of more than one year's duration. After the neonatal period, the dosage of erythromycin and tetracycline for congenital syphilitics who are allergic to penicillin should be individualized but need not exceed dosages used in adult syphilis of more than one year's duration. Tetracycline should not be given to children less than 8 years of age.

PREVENTIVE TREATMENT

Patients who have been exposed to infectious syphilis within the preceding three months are at high risk to incubate the disease. A serologic test for syphilis and a thorough physical examination should be performed to determine if active infection is present. Even if physical findings are negative these patients should be given preventive treatment (the regimen is the same as for early syphilis), at the time of the initial visit to abort their developing the disease.

We hope you find this information useful. Again, for elaboration on this material, or consultation on a problem case, telephone the State Department of Health collect at (515) 281-3031.

QUESTION BOX

(Continued from page 475)

provides important liaison between the centers and other mental health related state and federal agencies.

As of July 1, 1976, the Authority received its first state appropriation which is to be utilized in establishing and monitoring standards for mental health centers. By Iowa law, these standards must be in substantial conformity with the national standards recently developed by the Joint Commission on Accreditation of Hospitals. Located at the University of Iowa, the Mental Health Authority operates with a small staff and is able to make economical use of services provided by other Departments.

How does Iowa compare with other states in the provision of mental health care?

Compared with other states, Iowa enjoys a reasonably high level of tax supported mental health care provided at reasonable cost. Our four Mental Health Institutes are all accredited and rank in the top 10% nationally in professional staff/patient ratios. Though costs have been criticized, Iowa ranks in the lower 10% nationally in per capita investment in state hospitals. In spite of increasing admission rates, daily populations and lengths of stay have been reduced to a minimum comparing most favorably with states spending twice as much per citizen.

Our mental health centers system is envied by other states because of its broad coverage and local financial support. In Iowa there is no threat of closing centers because of withdrawal of federal funds. Unfortunately, few centers in Iowa are truly comprehensive and state funding may ultimately be necessary if additional needed services are to be provided.

As far as the number of psychiatrists per 100,000 population, Iowa is about average, having 5.8 compared to a median of 6.1. However, since only about 40% of all psychiatrists see private patients, a comparison of private practice with other states would probably be less favorable.

Medical Assistants

by BETTY EHLERT, CMA-A

1,815 PASS SPRING EXAMS

A total of 1,815 certificates—the highest number in history—were earned by those taking the spring certification examination of the American Association of Medical Assistants. Results of the examinations were released in September.

This record number includes 1,085 who passed the basic certification examination (Certified Medical Assistant), with the specialty certification (Administrative, Clinical or Pediatric) being awarded to 730 candidates

The basic certification examination and all three specialty examinations are given each year on the first Friday in June at more than 100 approved test centers throughout the country. In addition, the basic certification examination is administered each fall in the convention city on the Saturday immediately prior to AAMA's Annual Meeting.

The American Association of Medical Assistants offers these examinations as a service to both member and non-member assistants. Medical assisting instructors and students in AMA/AAMA or AMA/AAP/AAMA accredited medical assisting programs are also eligible to apply.

43 NEW CMAs IN IOWA

Iowans newly certified are:

Diane L. Bidwell, Ames—CMA-C, Cynthia Ann Blum, Earling—CMA-C, Patricia Ann Dinville, Pacific Junction—CMA, Willow Kay Dykstra, Rock Valley—CMA, Debra Sue Essick, Norwalk—CMA-C, Pamela Sue Foster, W. Burlington—CMA, Donna May Freeman, Fairfield—CMA-C, Rebecca Froehle, Cedar Rapids—CMA, Janene Marie Gourley, Corwith—CMA-C, Irene Meyer Guest, Council Bluffs—CMA-C, Delores A. Hartl, Cedar Rapids—CMA-C, Mary Ellen Hatley, Des Moines—C, Martha E. Haverkamp, Remsen—C, Bonnie Jean Hersom, Des Moines—CMA-C

Deborah Ann Huber, Waterloo—CMA-A, Sherri James, Maquoketa—CMA-C, Linnae N. Kenney, Indianola—CMA-A, Phyllis Jean Klaudt, Council Bluffs—CMA-C, Nina M. Kline, Waterloo—CMA, Sandy S. Klocke, Templeton—CMA, Dana Deann Knopic, Des Moines—CMA-C, Bonnie J. Koehler, Sioux Center—CMA, Rita Ann McDonald, Winterset—CMA, Charlotte Meyer, Winterset—CMA, Michelle Annette Naig, Monticello—CMA, Deborah Ann Odgaard, Ankeny—CMA-C

Mary M. Parker, Hiawatha—CMA, Jolene Janae Plagge, Latimer—CMA, Inez Rippentrop, Algona—CMA, Debra H. Roth, Cedar Rapids—CMA-C, Dorla J. Sansom, Des Moines—CMA-A, Karen Kay Schrad, Auburn—CMA, Luanne Marie Schrad, Auburn—CMA, Laurie K. Seidl, Carroll—CMA, Betty Lee Taylor, Waterloo-CMA-C, Teresa Ann Todd, Madrid—CMA, Margaret L. Walston, Adel—CMA-C, Ann Marie Warn, RT, Des Moines—CMA-A, Wava June Wessels, Applington—CMA-C

Congratulations to the Newly Certified Iowa Medical Assistants!

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About IOWA Physicians

Dr. Osamah El-Khatib, former Bronx, New York physician, has relocated in Dyersville. Dr. El-Khatib is a board eligible physician in internal medicine. He interned at New Britain, Connecticut, and completed his residency in internal medicine at Providence Hospital in Washington, D. C., and St. Luke's Hospital in New York City. . . . **Dr. Joseph Spearing,** Harlan, has been renominated to board of directors of Omaha-based Health Planning Council of the Midlands. . . . **Dr. Ross Yellen,** a general practitioner from Toronto, Canada, will begin a solo practice in Forest City in mid-November. Dr. Yellen received his medical training in Louvain, Belgium. Following postgraduate training in Canada, Dr. Yellen located in Toronto where he has been associated with the Toronto Medical Clinic for the past three years. . . . **Dr. M. C. Jones,** Boone, was recently named "Boss of the Year" by the Boone County Chapter of the American Business Women's Association.

Dr. K. J. Kroack, Buffalo Center, has accepted a student health position at South Dakota State University in Brookings, South Dakota. . . . **Dr. Jerald D. King,** Nevada, was recently named a Fellow in the American Academy of Family Physicians. . . . **Dr. Reas Anneberg,** Carroll, was guest speaker at recent meeting of District 13 Iowa Nurses Association. Dr. Anneberg spoke on new developments in the treatment and diagnosis of allergies. . . . **Dr. Thomas A. Brown** has opened a new office for the practice of ophthalmology in Des Moines.

Dr. John P. Barthel, Cedar Rapids, has been named student health physician at Cornell College in Mount Vernon. . . . **Dr. J. F. Veverka,** Prairie City, was recently presented a plaque by Iowa Academy of Family Physicians for his distinguished service as editor of the organization's magazine. . . . **Dr. Robert W. Schafermeyer,** National Health Service Corps physician in Eldora since 1974, is leaving the community to return to specialty training. He will remain in the Public Health Service. . . . **Dr. Sandy Gonzalez** began a family practice in Algona in November. Dr. Gonzalez received his medical education at the University of Madrid in Spain. He completed postgraduate training at both the University of Madrid Hospital and at a medical center in Puerto Rico, where he began his private practice of medicine in 1973. Dr. Gonzalez is a member of American College of Emergency Physicians and American College of Family Physicians. . . . **Dr. Paul From,** Des Moines, has been appointed Medical and Administrative Director of Technical Services Department at Des Moines' Mercy Hospital. A member of Mercy medical staff for the past 27 years, Dr. From initiated the Technical Services Department and has been a major contributor to its development and growth. . . . **Dr. Montague S. Lawrence,** Cedar Rapids, was guest speaker at recent meeting of Maquoketa Lions Club. Dr. Lawrence spoke on his work as a surgeon and member of the administrative staff at St. Luke's Hospital.

Dr. Ronald M. Larsen recently joined the staff at Kersten Clinic in Fort Dodge. Dr. Larsen received the M.D. degree at U. of I. College of Medicine and completed his residency in psychiatry at Washington University School of Medicine in St. Louis, Missouri. . . . **Dr. Michael Mickelson,** a Waterloo native, has been appointed assistant professor of orthopedics at U. of I. College of Medicine. Dr. Mickelson received the M.D. degree at U. of I. in 1972 and completed his residency in orthopedics at University Hospitals this year. . . . **Dr. Paul W. Wolpert,** Sioux

City, and **Dr. Mary L. Gannon,** Spencer, were recently named Fellows of American College of Surgeons. . . . **Dr. Keith A. Garber,** Corydon, was elected president of the Iowa Academy of Family Physicians at 28th annual meeting of the group in Des Moines. . . . **Dr. Robert C. Hardin,** professor at the U. of I. College of Medicine, was the guest speaker at recent meeting of Northeast Iowa Diabetes Unit. Dr. Hardin's topic "Research Trends in Diabetes." . . . **Dr. Clifford P. Goplerud,** professor in Department of Obstetrics and Gynecology at U. of I. College of Medicine, has been named president of Central Association of Obstetricians and Gynecologists.

John Weibel, D.O., has joined **Drs. John Mochal** and **Richard Myers** at Medical Associates Clinic in Independence. Dr. Weibel received his medical training at College of Osteopathic Medicine and Surgery in Des Moines. For the past five years he has been in general practice in West Union. . . . **Dr. Ramon Yaldua,** New Sharon, was recently inducted into the American College of International Physicians. Members of this organization must be graduates of foreign medical schools who have maintained a medical practice in the United States for at least five years. . . . **Dr. Darsham S. Gill** joined the medical staff at McCrary-Rost Clinic in Lake City on November 1. A Fellow of the American College of Surgeons and also a Fellow of the Royal College of Surgeons, Dr. Gill attended medical school at the London Hospital Medical College, University of London, England. He served his internship and residency in London and completed further postgraduate work in surgery in Canada where he has been in private practice. . . . **Dr. Jack Moyers,** professor and head of the Department of Anesthesia at U. of I. College of Medicine, was named president-elect of the American Society of Anesthesiologists at the group's recent annual meeting in San Francisco. . . . **Dr. J. C. Justin,** Mason City, was guest speaker at the October meeting of Wright County Medical Society. Dr. Justin spoke on neonatal jaundice. . . . **Dr. Lawrence DenBesten,** professor and vice chairman of the Department of Surgery at U. of I. College of Medicine, and **Dr. C. E. Hawtrey,** associate professor in Department of Urology, were guest speakers at recent Central Iowa Enterostomal Therapy Seminar at Iowa Lutheran Hospital in Des Moines.

Morbidity Report for October 1976

Disease	*Oct. 1976*	*1976 to Date*	*1975 to Date*	*Most October Cases Reported From These Counties*
Amebiasis	2	31	19	Jackson, Johnson
Brucellosis	31	45	19	Dubuque
Chickenpox	309	10127	7012	Clay, Dubuque, Polk
Conjunctivitis	142	1677	1089	Scattered
Encephalitis, St. Louis	1	3	—	Linn
Erythema infectiosum	3	165	159	Franklin, Guthrie, Hancock
Gastrointestinal viral inf.	2910	20228	17860	Davis, Linn
Giardiasis	1	25	24	Dallas
Hepatitis				
Infectious	8	104	150	Polk, Linn
Serum	11	74	82	Polk
Unspecified	2	19	27	Linn, Montgomery
Impetigo	182	762	647	Scattered
Infectious mononucleosis	127	909	1004	Johnson, Scott
Influenza-like illness	3627	44151	41044	Buchanan, Davis, Linn, Story
Meningococcal meningitis	1	11	6	Polk
Meningitis				
Aseptic	2	13	10	Linn
Type unspec.	4	7	29	Linn, Louisa, Montgomery
Meningoencephalitis, due to mumps	1	1	—	Polk
Mumps	85	1330	1153	Scattered
Pediculosis	292	653	317	Scott, Story
Pneumonia	90	857	936	Scott
Rabies in animals	9	117	90	Scattered
Rheumatic fever	3	20	13	Buchanan
Ringworm				
Body	28	223	242	Scattered
Scalp	4	19	9	Scattered
Rubella (German measles)	1	88	29	Iowa
Rubeola (measles)	1	44	621	Tama
Scabies	161	640	452	Dubuque, Polk
Streptococcal infections	1035	12660	7866	Scattered
Tuberculosis				
Total ill	13	97	102	Polk
Bact. positive	12	85	67	Polk
Venereal diseases				
Gonorrhea	572	5609	5875	Linn, Polk, Scott
Syphilis	52	304	249	Scattered

Laboratory Virus Diagnosis Without Specified Clinical Syndrome Coxsackie B2 infection 3, Cytomegalovirus 5, Echovirus (type 4) 5, (type 30 isolated) 1

Clonorchis sinuses infestation 1

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